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ABSTRACT

The purpose of the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment's (CSAT's) Cannabis Youth Treatment (CYT) Project Cooperative Agreement was to test the relative effectiveness and cost-effectiveness of a variety of interventions designed to eliminate marijuana use and associated problems in adolescents and to provide validated models of these interventions to the treatment field. The target population was adolescents with cannabis use disorders of abuse or dependence, as defined by the American Psychiatric Association (1994), who were assessed as appropriate for treatment in outpatient settings. This manual guides therapists and their supervisors in using the multidimensional family therapy intervention with adolescents and their caregivers. Multidimensional family therapy is the multisystemic family-focused treatment described in this manual for experienced family therapists that includes 12 weeks of in-clinic and telephone sessions working with individual adolescents and their families. MDFT targets the psychosocial functioning of individual family members, the family members' relationships, and influential social systems outside the family. The approach strives for consistency and a coherent and logical connection among its theory, principles of intervention, and intervention strategies and methods. The intervention methods derive from target population characteristics, and they are guided by research-based knowledge about dysfunctional and normal adolescent and family development. Interventions work within the multiple ecologies of adolescent development, and they target the processes known to produce and/or maintain drug taking and related problem behaviors. Appendixes include key terms and

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abbreviations, administrative issues in implementing MDFT, a summary of the MDFT research program, and a detailed account of the CYT study. (Contains 265 references.) (GCP)

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Multidimensional Family Therapy For Adolescent Cannabis Users

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CYT

Cannabis Youth Treatment Series

Volume 5

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Multidimensional Family Therapy for Adolescent Cannabis Users

Howard A. Liddle, Ed.D.

CYT

Cannabis Youth Treatment Series
Volume 5

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I. Background on the CYT Cooperative Agreement

Goals and Objectives

The purpose of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment's (CSAT's) Cannabis Youth Treatment (CYT) Project Cooperative Agreement was to test the relative effectiveness and cost-effectiveness of a variety of interventions designed to eliminate marijuana use and associated problems in adolescents and to provide validated models of these interventions to the treatment field. The target population was adolescents with cannabis use disorders of abuse or dependence, as defined by the American Psychiatric Association (1994), who were assessed as appropriate for treatment in outpatient settings.

Overview of the Study

The study was conducted in collaboration with staff from Chestnut Health Systems (CHS–MC) in Bloomington and Madison County, Illinois; University of Connecticut Health Center (UCHC) in Farmington, Connecticut; Operation Parental Awareness and Responsibility (PAR) in St. Petersburg, Florida; and Children's Hospital of Philadelphia (CHOP). It involved five manual-based, expert-supported treatment conditions:

- **Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT5)**—This is a five-session treatment composed of two individual sessions of motivational enhancement therapy and three group sessions of cognitive behavioral therapy. The MET sessions focus on factors that motivate clients to change. In the CBT sessions, clients learn skills to cope with problems and meet needs in ways that do not involve marijuana or alcohol.

- **MET/CBT5 + CBT7**—This treatment is composed of the complete MET/CBT5 treatment combined with seven additional group sessions of CBT. The primary difference between this and MET/CBT treatment is the provision of more CBT sessions over a longer (12-week) period.

- **Family Support Network (FSN)**—The family support network treatment includes the MET/CBT5 + CBT7 treatment, with the provision of additional support for families (home visits, parent education meetings, parent support group), aftercare, and case management.

- **Adolescent Community Reinforcement Approach (ACRA)**—The adolescent community reinforcement approach is composed of 12 individual sessions with an adolescent and/or the adolescent's "concerned other." It focuses on teaching alternative skills to cope with problems and meet needs, with an emphasis on the adolescent's environment. Concerted effort is made to change the environmental contingencies—both positive and negative—related to continued substance use.

- **Multidimensional Family Therapy (MDFT)**—Multidimensional family therapy is the multisystemic family-focused treatment described in this manual for experienced family therapists that includes 12 weeks of in-clinic and telephone sessions working with individual adolescents and their families. MDFT targets the psychosocial functioning of individual family members, the family members' relationships, and influential social systems outside the family.

These treatments vary by mode. The first three are combinations of individual and group approaches, and the last two combine individual and family or significant-other treatment approaches. Further, the MET/CBT and ACRA interventions are based on behavioral treatment approaches, whereas the FSN and MDFT interventions are based on family treatment approaches. Third, they vary in terms of resource intensity and cost when the final analyses are completed.

At each site, approximately 150 adolescents were randomly assigned to one of three conditions. At UCHC and PAR, they were assigned to the brief MET/CBT5 or one of the two other individual/group combinations of MET/CBT5 + CBT7 or FSN. At CHS–MC and CHOP, adolescents were randomly assigned to the MET/CBT5 treatment or one of the two individual/family approaches of ACRA or MDFT. All conditions were replicated at two or more sites and were manual driven with expert work groups supporting them. All clients were assessed at intake and at 3, 6, and 9 months. To validate clients' responses, urine tests and collateral assessments were done at intake and at 3 and 6 months.

Expected Products

The 3-year study began in October 1997. Starting in spring 1998, adolescents with marijuana abuse or dependence problems who were appropriate for outpatient treatment were assigned to one of the treatment conditions. The recruitment and treatment phase of the study lasted 12 to 15 months. Clients were followed up on a flow basis from 9 months after their intake through spring 2000, and analyses were conducted during the project on baseline needs, costs, outcomes, and cost-effectiveness.

The study has produced a series of research and treatment manuals that can be used by other providers and evaluators, as well as scientific findings on the characteristics of adolescents entering outpatient treatment, the effectiveness of the five treatment approaches, and estimates of their costs and cost-effectiveness. These materials and findings will be distributed through a variety of channels, including professional conferences, journal articles, annuals, and the project's Web site (www.chestnut.org/).

II. MDFT Approach to Cannabis Treatment

Evolution of the MDFT Protocol

MDFT is a family-based outpatient treatment developed for clinically referred adolescents with drug and behavioral problems (Liddle, 1992). The approach strives for consistency and a coherent and logical connection among its theory, principles of intervention, and intervention strategies and methods. The intervention methods derive from target population characteristics, and they are guided by research-based knowledge about dysfunctional and normal adolescent and family development. Interventions work within the multiple ecologies of adolescent development, and they target the processes known to produce and/or maintain drug taking and related problem behaviors. Similar developmental challenges may be common to all adolescents and their families, and these are central assessment and treatment focuses (Liddle & Rowe, 2000). At the same time, considerable variation may be demonstrated in the expression of these generic developmental challenges. In MDFT, therapists are sensitive to these individual adolescent and family variations. With each case, therapists seek to understand the unique manifestations of developmental problems.

MDFT is not a narrowly focused treatment protocol. The approach has been operational in different treatment applications. Different versions of this approach have been developed and tested according to several factors, including study population characteristics, the intent of the study at the time, and findings from an ongoing clinical research program on the MDFT model. The MDFT research program to date is summarized elsewhere (Liddle & Hogue, 2001). The approach has varied in elements such as *treatment length* (e.g., in one study, 16 sessions over 5 months; in another, a flexible number of sessions from 4 to 25), *dosage* or *intensity* (the amount of therapist contact per week), *intervention locale* (in-clinic or a combination of in-clinic/home-based locales), inclusion of *particular therapeutic methods* (e.g., clinical use of within-treatment drug screens and case management), and *formats* (e.g., using a single therapist or a therapist and therapist's assistant [case management assistant]). This manual details the version tested in the CYT study funded by CSAT from 1997 to 2000. MDFT has been used effectively by both experienced family therapists and line clinicians with no family therapy experience. Ideally, the person who trains and/or supervises the implementation of MDFT should have a background in family therapy and/or child development.

The MDFT approach has been developed and tested since 1985 in four major, completed randomized clinical trials; a randomized prevention trial; and several treatment development and process studies, which have illuminated core change-related aspects of the therapeutic process (Liddle & Hogue, 2001). Since 1991, this work has been performed through the Center for Treatment Research on Adolescent Drug Abuse. This was the first National Institutes of Health/National Institute on Drug Abuse- (NIDA-) funded research center on adolescent substance abuse. MDFT studies have been conducted at various urban locations in the United States, including

Philadelphia, the San Francisco Bay area, central Illinois, and Miami. The study populations were ethnically diverse (and their problem severity varied as well), from high-risk subjects in early adolescence to multiproblem, juvenile justice-involved female and male adolescent substance abusers with co-occurring disorders. This approach has been recognized as one of a new generation of comprehensive, multicomponent, theoretically derived, and empirically supported adolescent drug abuse treatments (Center for Substance Abuse Treatment, 1999; Lebow & Gurman, 1995; National Institute on Drug Abuse, 1999; Nichols & Schwartz, 1998; Selekman & Todd, 1990; Stanton & Shadish, 1997; Waldron, 1997; Weinberg et al., 1998; Winters, Latimer & Stinchfield, 1999). MDFT is included in NIDA's list of empirically supported drug treatments (www.nida.nih.gov/) and in the American Psychological Association's Division 50 issue on empirically supported drug therapies in *The Addictions Newsletter* (Liddle & Rowe, 2000). MDFT is also included in the Office of Juvenile Justice and Delinquency Prevention's Strengthening America's Families—Exemplary Programs Initiative (www.strengtheningfamilies.org/) with the Center for Substance Abuse Prevention (CSAP). MDFT is being tested within CSAT's Initiative on Adolescent Treatment Models, formerly known as the funding initiative on Exemplary Adolescent Treatment Programs. Awards recognizing the approach have been presented by the American Psychological Association (1991), the American Family Therapy Academy (1995), the American Association for Marriage and Family Therapy (1996), and the Florida Association for Marriage and Family Therapy (2000).

Overview of the Treatment Model Intervention

It is important to have a sufficiently complex, multivariate framework to comprehend and act on what could be called the core clinical phenomena—the situations and processes that determine poor developmental outcomes and that, therefore, should be targeted for change. A multidimensional perspective on adolescent substance abuse and behavior problems, and thus a multidimensional framework, orients therapy and the therapist. This framework, made up of empirically based knowledge about how adolescents develop and how development is derailed, drives the therapy.

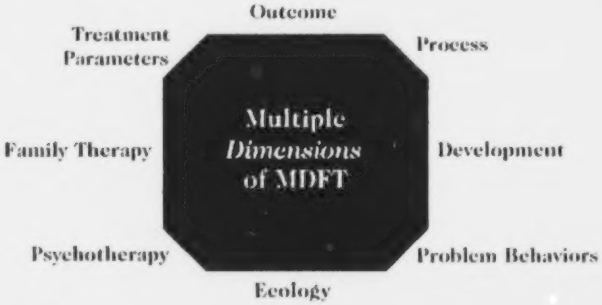
In research, design and statistical methods are tools to answer research queries. Similarly, in treatment, therapy techniques serve the overall approach. Techniques are tools; they are a means to access and facilitate adaptive change. MDFT therapists are taught an overarching conceptual framework that helps them appraise and respond to diverse clinical situations. The MDFT framework focuses on several areas that are critical to a clinician's understanding of how adolescent drug problems form, develop, and continue and how they can be replaced with adaptive and prosocial development and competence. Therapists are developmentalists in the sense of having a primary job of understanding how development has gone astray and devising means to facilitate its retracking.

Dimensions of Multidimensional Family Therapy

MDFT is an integrative therapeutic philosophy and clinical approach. It relies on the contemporary empirical knowledge base of risk and protective factors and known determinants of adolescent substance abuse to assess and intervene in the lives of teenagers and their parents.

Figure 1 answers the obvious and immediate question that comes from a first encounter with MDFT: What are the dimensions of multidimensional family therapy? The following section gives a thumbnail sketch of each of these dimensions that reflect different aspects of the model's characteristics as well as the sources of influence on the MDFT approach over the years.

Figure 1. Dimensions of Multidimensional Family Therapy



Outcome

The outcome dimension refers to the model's and the therapist's overriding orientation. In every contact with the case or with persons with whom the family interacts, the therapist asks the question, "What are the optimal and 'good enough' outcomes in this interaction?" Thus, outcome refers here to overall case outcomes (e.g., abstinence or great reductions in the use of illegal substances and the connection of a teen to prosocial influences and activities) as well as to smaller, more proximal outcomes (e.g., the outcome of a phone conversation with a parent or the outcomes of a session). This outcome orientation permeates every session and every contact with a client. This outcome orientation encourages, indeed organizes, a therapist to think in terms of long-term, intermediate, and short-term goals and the mechanisms to achieve them.

Process

Whereas a goal orientation is a necessary and critical starting place in clinical work, an outcome orientation is incomplete without a vision of the way particular outcomes might be achieved. Process refers to the way the hoped-for change is facilitated.

Development

Development is the knowledge base of clinical work. Therapists use their knowledge of development to set an overall treatment course, as well as to pinpoint particular interventions or adjust those already in motion. Knowing about the expected and normal changes in the parent–adolescent relationship or normal changes in the individual aspects of a teen's development (e.g., focus on self-identity, sexual experimentation, cognitive changes allowing perspective taking) informs the therapist's assessment and intervention ability. An appreciation and the use of developmental knowledge also include a focus on the teen's family members.

Problem Behaviors

Problem behaviors are deviations from normal development. In research literature, the developmental psychopathology perspective allows clinicians and researchers to understand the development of problem behaviors over time, their interrelationship and sequencing, and the risk and protective factors of high-risk adolescent behaviors. As a systemic approach, MDFT includes the behaviors of the caretakers most involved with the teenager.

Ecology

Adolescent development and treatment necessarily includes the multiple psychosocial ecologies of teens and their families. The ecology dimension reminds the clinician not to narrow his or her understanding to the individual or family level. The therapist has available multiple assessment tools and levels of intervention—and some of these pertain to adolescents' everyday functioning in social ecologies outside their families.

Psychotherapy

This sphere of influence pertains to particular forms of therapy that have influenced the MDFT approach. Particularly in MDFT's early development, behavioral therapies and client-centered therapies influenced the approach. In recent years, thinking and methods from both the drug counseling and chemical dependency perspectives have informed the MDFT approach.

Family Therapy

Structural Therapy (Minuchin, 1974) and Strategic Family Therapy (SFT) (Haley, 1976) were among the earliest influences on the MDFT approach, which was first called Structural-Strategic Family Therapy (Liddle, 1985). The influences of SFT can be observed in MDFT's adoption of the enactment principles of change and intervention. Problem Solving Therapy, which emphasizes crafting a strategy for treatment, thinking in stages of therapy and of change, and focusing on out-of-session tasks as a complement to in-session change enactments, has been a major influence on the MDFT approach as well. Stanton and Todd's (1982) integrative structural and strategic therapy with heroin-addicted adults also was a significant influence in MDFT's early days.

Treatment Parameters

This dimension refers to the structural or organizational aspects of the treatment approach. In the CYT study, treatment duration was 12 weeks, but the level of therapist contact and case contact time varied according to the needs of the case as determined by the clinician and supervisor. Sessions were held in clinical offices, the home, school, juvenile court, or wherever the appropriate parties could be convened. Using the phone—to call the parent, adolescent, or other family members (e.g., to follow up after face-to-face contact, make more suggestions to follow the action plan set in the previous contact)—is common. It is important not to let limits imposed by traditional ways of service delivery (e.g., in-clinic sessions, 1 hour of treatment per week) define what is perceived to be needed with multiproblem adolescents and their families.

Defining the Clinical Model in the CSAT–CYT Multisite Project

In the CSAT-funded CYT project, MDFT is defined in terms of the following formula:

> 4 x 3 = 12
>
> MDFT is 4 (modules) x 3 (stages) = 12 (weeks)
>
> "With every case, I'll work four modules
> in three stages over 12 weeks."

MDFT includes four modules: adolescent, parent, family interaction, and extrafamilial systems. We use "module" in several ways. It can refer to (1) the various knowledge bases that constitute our understanding of drug and behavior problems, (2) the intervention targets or locales where the interventions aim to facilitate prosocial or healing processes and block dysfunctional processes or actions, or (3) the pathways to and mechanisms of change. Treatment has three stages: (1) build the foundation, (2) prompt action and change by working the themes, and (3) seal the changes and exit.

General Theoretical Assumptions and Approach

Theory of Dysfunction

Presumptions about how problems develop and are maintained or how they are exacerbated are fundamental to any intervention and to an overall model. Ideally, there is a connection between how dysfunction develops and continues and a model's techniques. Interventions, which are actualized using particular techniques, target certain content, personal characteristics, or interpersonal processes. A model can also specify processes or means by which the therapy techniques affect the intervention targets—such as specific domains of functioning—to facilitate improved overall functioning. Key components of MDFT's theoretical underpinnings derive from family and developmental psychology (Bronfenbrenner, 1979; Kaye, 1985; Minuchin, 1985) and developmental psychopathology (Sroufe & Rutter, 1984). Epidemiological, clinical, and basic research studies indicate that adolescent drug abuse is a multidimensional disorder (Brook et al., 1988; Bukstein, 1995; Newcomb, 1995). Correspondingly, the MDFT treatment model's philosophy and methods reflect the field's assessment of this disorder (Segal, 1986). A commitment to translate and use clinical and basic research has been a guiding principle in this model's development.

Risk factors

Drug use and drug abuse correlates have been organized into several domains—individual, family, peer, school, neighborhood/community, and societal (Hawkins, Catalano & Miller, 1992). These domains reflect both the intervention philosophy and focuses of MDFT. The correlates—the pieces of the puzzle (Petraitis, Flay & Miller, 1995)—of adolescent substance use and abuse include systemic-level factors, such as extreme economic deprivation, and proximate ones, such as family conflict and disruptions in family management. Individual factors, such as parental psychopathology or drug and alcohol use, and an adolescent's failure to bond to school, problems in emotion regulation, or poor interpersonal skills and peer relations are implicated in drug problem development as well (Brook et al., 1988).

MDFT's multisystemic family-based approach, rooted in social science versions of systems thinking (Bronfenbrenner, 1979; Minuchin, 1985), is consistent with contemporary understandings of risk and protective processes. Risk factors do not exist or operate in isolation—multiple risk factors interact over time and can have a cumulative impact (Bry, McKeon & Pandina, 1982). Their interaction within a given timeframe can create synergistic effects yielding higher levels of risk, deteriorating functioning, and few development-enhancing circumstances.

Risk factors are also mutually influential and reinforcing (Brook, Whiteman & Finch, 1993; Thornberry, 1996). This conceptualization coincides with contemporary ideas about reciprocal effects in human relationships (Lerner & Spanier, 1978; Sameroff, 1975). An adolescent's academic problems and low commitment to school might make normal developmental tension at home worse. Avoidance of conflictual topics and negative interactions are common coping behaviors in clinical families (and others) in this situation. Together, these circumstances create the motivation and opportunity for affiliating with like-problem peers.

Poor family-management skills may be related to a parent's functioning in other domains, such as parental psychopathology or family disruption created by unemployment. Family management difficulties set the stage for inconsistent parental monitoring, increased frustration, and an inability to address the normal challenges of parenting teenagers. Temperamentally difficult children and teenagers can influence family management strategy, ability, and consistency. Subtle rejection of these children and teenagers by parents is not uncommon (Baumrind & Moselle, 1985). Parents in this situation often experience loosening of their influence and control over the adolescent as the teenager's peer affiliations become stronger (Dishion et al., 1995; Rueger & Liberman, 1984). Although decreased direct parental influence during the adolescent years is normal, in clinical families parents are known to have, or view themselves as having, very little parental influence (Patterson & Chamberlain, 1994; Schmidt, Liddle & Dakof, 1996). Some researchers have argued that part of the deviation-amplifying process (and part of what needs to change) involves increases in parents' tolerance for deviant behavior (Bell & Chapman, 1986).

Protective factors

A risk factor focus must be complemented by a therapist's ability to know about, focus on, and expand protective factors—particularly those having to do with establishing connection to prosocial pursuits and new kinds of relationships within and outside the family. Eliciting hidden strengths is critical (Minuchin & Fishman, 1981). A basic goal is establishing a receptive mindset in both the parent and teenager regarding the fundamental role played by personal relationships in promoting development in the adolescent's life.

A good relationship with one's parents buffers against development of problem behavior (Wills, 1990). Many recent studies underscore the importance of parents to their teenager's ongoing development (Resnick et al., 1997), as well as the parents' capacity to stop the progression of problems once they have begun. Steinberg, Fletcher & Darling (1994) found that particular parenting practices, such as providing emotional support, can reverse the course of negative peer influence even after problem behavior has started. MDFT's primary goals are to change the adolescent–parent relationship in developmentally normative ways and to change the family environment generally, but family relationships are not the only target of change in MDFT.

A therapist does not simply memorize the list of risk and protective factors and seize opportunities to discuss them. Rather, clinicians assess and intervene in transactional and interinstitutional processes while using and translating the knowledge base of risk and protective factors, which constitutes a higher objective and skill. Assessing and intervening in the dynamic "moving targets" of reciprocal interactions (i.e., an adolescent's behavior elicits a parent's reactions and parenting practices influence the teenager's behavior and elicit reactions [Lytton, 1990; Stice & Barrera, 1995; Vuchinich, Bank & Patterson, 1992]) is a major challenge.

Adolescent development

The MDFT approach targets a youth's relationships across developmental niches. For example, considerable time is spent with the adolescent in individual sessions in this family-based treatment to gain indirect access to his or her intrapersonal world and peer network. These therapeutic contacts vary. Sometimes, they are sessions in the usual sense, but on other occasions they may also take the form of an outing to a movie or a restaurant or an adolescent-led guided tour of the teenager's neighborhood. The role of influential antisocial peers in the development and amplification of child and adolescent problem behaviors is well established (Dishion et al., 1995). Because adolescents are generally not willing to discuss the details of their antisocial activities with peers in the presence of their parents, access to the adolescent's conception of and activities within his or her peer world, as well as to the intrapersonal aspects of the adolescent's development (Oyserman & Markus, 1990), is gained by spending time with the teenager alone (Liddle, 1995). Varying the treatment setting to forge relationships with individuals who have "been there and done that" as far as the treatment programs are concerned has been a key factor in gaining the needed access to the teen's psychological and emotional world. Access is earned. A teen's referral to treatment by juvenile court or his or her coercion into therapy by a parent or school official has nothing to do with gaining the needed access to the adolescent's psychosocial world. Only a personal relationship between the therapist and adolescent can create the kind of access that predicts change.

For practical clinical reasons and on the basis of research evidence, adolescent problem behavior and drug abuse are defined as problems of development (i.e., deviations in the normal developmental course or failures to successfully meet developmental challenges). These problem behaviors are determined by the interplay between the youth and the social systems—family, peer, school, and community or neighborhood in which he or she lives. Adolescent drug abuse is "embedded within the proximal peer environment, which in turn, emerges and is amplified within a context of low adult involvement and monitoring" (Dishion et al., 1995, p. 803). Because of the many factors involved in the creation and continuation of adolescent drug use and abuse and the number of functional impairments that exist with drug-abusing adolescents, a broad-based, comprehensive treatment strategy is necessary (Kazdin, 1994; Newcomb, 1992). The therapist devises an individualized treatment plan targeting aspects of functioning in individual, familial, and extrafamilial systems known to be related to the creation and continuation of drug abuse and related problem behaviors. The treatment plan is a collaborative effort; each family member and influential extrafamilial other is involved in its creation. Adolescent substance abuse is a systemic problem—a set of behaviors and circumstances that combine to derail attainment of current and future developmental milestones.

Key Concepts:

- The family is a primary context of healthy identity formation and ego development.
- Peer influence is contextual; it interacts with the buffering effects of a family against the deviant peer subculture.
- Adolescents need to develop an interdependent rather than an emotionally separated relationship with their parents.

Symptom reduction and enhancement of prosocial and normative developmental functions in problem adolescents occur by targeting the family as the foundation for intervention and simultaneously facilitating growth and healing processes in several domains of functioning and across several systemic levels.

Theory of Change

Adolescent developmental psychology and psychopathology research has determined that (1) the family is the primary context of healthy identity formation and ego development, (2) peer influence operates in relation to the family's buffering effect against the deviant peer subculture, and (3) adolescents need to develop an interdependent rather than an emotionally separated relationship with their parents. Therefore, a multidimensional change perspective holds that symptom reduction and enhancement of prosocial and normative developmental functions in problem adolescents occur by (1) targeting the family as the foundation for intervention and (2) simultaneously facilitating curative processes in several domains of functioning and across several systemic levels. Particular behaviors, emotions, and thinking patterns known to be related to problem formation and continuation are replaced by new behaviors, emotions, and thinking patterns associated with appropriate intrapersonal and familial development.

Key Concepts:

- MDFT systematically assesses and targets adolescent functioning in six health-related domains: drug use, identity development and autonomy, peers and peer influence, bonding to prosocial institutions, racial and cultural issues, and health and sexuality.
- Interventions have both intrapersonal and interpersonal aspects.

MDFT systematically assesses and targets adolescent domains of functioning: drug use, adolescent identity development and autonomy, peers and peer influence, bonding to prosocial institutions, racial and cultural issues, and health and sexuality. In addition, MDFT intervention techniques have both *intrapersonal* (i.e., feeling and thinking processes) and *interpersonal* (i.e., transactional patterns among family members or between a family member and extrafamilial persons) aspects. For example, changing the parenting practices of parents of adolescent drug abusers involves addressing personal aspects of the parents' lives apart from their roles as parents. Thus, the approach also conceives of intervention targets chronologically. Change in particular areas first is used as a departure point for subsequent, and usually more difficult, areas of work. Recent process studies have provided beginning empirical support for this epigenetic, multiperson, and multidomain framework for change (Diamond et al., 1999; G.M. Diamond & Liddle, 1996; G.S. Diamond & Liddle, 1996).

Because teenagers who abuse drugs also generally have functional impairments in two or more domains, MDFT simultaneously targets all domains in which there is poor functioning. The therapist reviews the risk factors for problems of interaction involving relevant persons in the adolescent's life as well as interactive problems or effects across domains.

Clinical problems or symptoms are seen as processes that involve synergistic and cumulative effects—the unfolding and worsening of active risk factor dynamics. Therapists try to slow or stop the momentum of these interacting risk and development-derailing processes by replacing them with hopeful, relationship-oriented, and concrete alternatives.

The nature and strength of these cascading negative processes create the rationale for multicomponent and comprehensive interventions. As drug use severity increases, when such levels exist alongside several risk (but few protective) factors, and when such development-detouring processes have been present over extended periods, the processes needing change have become quite stable. Although easy to identify, these processes are a challenge to change (Loeber, 1991). When advanced, the problem behaviors have become interdependent elements of the adolescent's lifestyle (Newcomb & Bentler, 1989). This is most common with teenagers who were early drug users and who exhibited behavior problems in childhood (Kandel, Kessler & Margulies, 1978; Kellam et al., 1983; Shedler & Block, 1990). In these situations, change in more functional domains will be required to decrease the drug taking, correlated behavior problems, and lifestyle patterns and to increase competence and developmental adaptation. Research on successful maintenance of drug-free lifestyles of adolescents following residential treatment reveals that most favorable outcomes occur after changes in several functional domains (Brown et al., 1994).

Key Concept:

The amount and the nature of the time a therapist spends with each case, his or her attention to the implementation details of the MDFT model, and the nature and quality of the clinical supervision influence case outcome.

In the context of understanding the formidable forces involved in problem development and effective intervention, it is important to maintain a deep appreciation of the human elements of working with drug-using teens and families. The therapist's caseload and high-quality, consistent, and clinically focused supervision (versus administrative supervision) influence case outcome and model development (Schoenwald et al., 2000). These sensibilities—respect for the work's difficulty and cognizance of the circumstances required to do this work effectively—are critically important in therapy and therapist development (Bank et al., 1991; Liddle, Becker & Diamond, 1997; Linehan, 1996).

Key Concept:

Multiple risk factors and a network of biopsychosocial influences have created an adolescent's drug abuse; hence, multiple dysfunction-producing and dysfunction-maintaining characteristics and processes must be targeted for change.

Problem behavior can desist when meaningful concrete alternatives are created, accepted, attempted, and adopted by the adolescents and families.

Motivating both the parents and teenager is a therapist's responsibility, and specific techniques to accomplish these short-term objectives have been developed and tested. (See Adolescent Engagement Interventions on page 62 and Parenting Relationship Interventions on page 107 for descriptions of these techniques [Diamond et al., 1999; Liddle & Diamond, 1991; Liddle et al., 1998; Schmidt, Liddle & Dakof, 1996].) If multiple risk factors (Newcomb, 1992) and a network of influences (Brook, Nomura & Cohen, 1989) have created and maintained adolescent drug abuse, then the same complex of interrelated influences must be systematically assessed and targeted for change.

Key Concept:

Assessing the multiple domains of adolescent and family functioning is not accomplished in a session or two. It occurs over the first several sessions with each family member alone, in conversation with the entire family and extended family, and with parents and the adolescent together.

The therapist's systematically organized and planned conversations with parents, teenagers, and other family members focus on past, current, and hoped-for circumstances in the multiple ecologies (Liddle, 1994a). Focusing on and assessing multiple domains occurs over the first several sessions with each family member alone, in family conversations that may include extended family, and with the parents and adolescent together (Liddle, 1995).

Key persons in the adolescent's environment (e.g., those in school or the juvenile justice system; peers) are included in the treatment. For example, a therapist may expend considerable time in helping organize a meeting between school officials and parents. Many parents are unaccustomed to or unskilled in orchestrating such events. Reestablishing a teenager's affiliation with some aspect of school (e.g., prosocial activities, academic mastery) or a job training or work-related alternative is a vital part of adolescent drug treatment.

Adolescent treatment must be practical. The therapist may work as a coach with the teenager and parents—preparing them for a school conference and defining possible and desirable outcomes. In another case, the focus might be on the teenager's noncompliance with juvenile justice system sanctions and the influential role a parent might play in an upcoming court hearing.

Although MDFT has a practical, results-oriented focus, new behavioral alternatives or potential solutions are not offered prematurely. Problem behaviors, such as affiliating with drug-using peers and disengaging from school and family relationships, are both interrelated and stable. MDFT interventions take into account the relationships, interactions, and factors that contribute to such connections.

Early treatment efforts include conversations focusing on the specific life circumstances of the teenager and parents, and small steps toward larger changes are introduced gradually. These small steps might involve discussions with the teen in which he or she is helped to evaluate different areas of his or her life.

Key Concept:

Attempts to implement problem solving in relationships will not work without the developmentally appropriate levels of attachment and communication having been reached.

The principle of relational epigenesis (Wynne, 1984) is an overall guide for problem assessment and intervention sequencing. This theory proposes a preferred sequence of developmental processes (i.e., attachment or caregiving is an early-stage relationship process, whereas mutuality in relationships is a more evolved, later-stage process characteristic). Although these processes overlap, like all developmental stages, optimally they follow one another in a predictable way (i.e., attachment or caregiving, communicating, joint problem solving, mutuality). When the preferred sequence of development or skill acquisition does not occur, functioning is impaired. In family therapy this means that attempts to implement problem solving in relational systems will not work without the requisite functioning or developmental levels of attachment and communication having been reached (Doane, Hill & Diamond, 1991). For example, it is difficult for parents to feel motivated to try new parenting behaviors if their basic emotional commitment to parenting has weakened (Dix, 1991; Liddle et al., 1998; Patterson & Chamberlain, 1994). In this "first things first" philosophy, the therapist is guided by questions such as, "What is getting in the way of the behavior of interest?" The therapist then attends to those barriers.

So far, this discussion has focused on the theoretical and empirical bases of the MDFT treatment model. The clinical principles of MDFT are presented next. Then, for the remainder of the manual, theory–research–practice connections within each module of the core approach are discussed.

Principles of Multidimensional Family Therapy

Therapy principles are defined as fixed or predetermined rules guiding clinical orientation and behavior (a therapist's prescribed behaviors and proscribed behaviors; Waltz et al., 1993).

Principles of Multidimensional Family Therapy

1. Adolescent drug abuse is a multidimensional phenomenon.
2. Problem situations provide information and opportunity.
3. Change is multidetermined and multifaceted.
4. Motivation is malleable.
5. Working relationships are critical.
6. Interventions are individualized.
7. Planning and flexibility are two sides of the same therapeutic coin.
8. Treatment is phasic, and continuity is stressed.
9. The therapist's responsibility is emphasized.
10. The therapist's attitude is fundamental to success.

The following are the 10 principles of MDFT:

1. **Adolescent drug abuse is a multidimensional phenomenon.** Its conceptualization and treatment are guided by an ecological and developmental perspective. Developmental knowledge informs interventions—presenting problems are defined intrapersonally, interpersonally, and in terms of the interaction of multiple systems and levels of influence.

2. **Problem situations provide information and opportunity.** The current symptoms of adolescents or other family members, as well as crises and complaints pertaining to the adolescent, provide not only critical assessment information but also important intervention opportunities.

3. **Change is multidetermined and multifaceted.** Change emerges from interaction among systems and levels of systems, people, domains of functioning, and intrapersonal and interpersonal processes. Assessment and intervention give indications about the timing, routes, or kinds of change that are accessible and possibly efficacious with a particular case. A multivariate conception of change commits the clinician to a coordinated and sequential working of multiple change pathways and methods.

4. **Motivation is malleable.** Motivation to enter treatment or to change will not always be present with adolescents or their parents. Treatment receptivity and motivation vary in individual family members and extrafamilial others. Resistance is normal. "Resistant" behaviors are barriers to successful treatment implementation, and they point to important processes for therapeutic focus. It is difficult for adolescents and families to create lasting lifestyle changes.

5. **Working relationships are critical.** The therapist makes treatment possible through practically oriented, outcome-focused working relationships with family members and extrafamilial sources of influence and through articulation of personally meaningful relationship and life themes. These therapeutic themes emerge as a result of inquiry about generic individual and family developmental tasks and the idiosyncratic aspects of the adolescent and family's development.

6. **Interventions are individualized.** Although they have generic aspects (e.g., promoting competence of adolescents or parents inside and outside the family), interventions are customized according to each family, each family member, and the family's environmental circumstances. Interventions target known etiologic risk factors related to drug abuse and problem behaviors, and they promote protective intrapersonal and interpersonal processes associated with positive developmental outcomes.

7. **Planning and flexibility are two sides of the same therapeutic coin.** Case formulations are socially constructed blueprints that guide ongoing treatment because formulations are revised on the basis of new information and in-treatment experiences. In collaboration with family members and relevant extrafamilial others, therapists continually evaluate the results of all interventions. Using this feedback, they alter the intervention plan and modify particular interventions accordingly.

8. **Treatment is phasic, and continuity is stressed.** Particular standard operations (e.g., adolescent engagement and theme formation), parts of a session, whole sessions, phases of therapy, and therapy overall are conceived and organized in phases. Continuity—linking pieces of the therapeutic work together—is important. Sessions have parts, and they are woven together into seamless wholes. Similarly, there is a weaving together of the parts of treatment and an active attempt by the therapist to maintain continuity and linkages between sessions and "chunks" of therapy.

9. **The therapist's responsibility is emphasized.** Therapists are responsible for (1) promoting participation and enhancing motivation of all relevant persons, (2) creating a workable agenda and clinical focus, (3) devising multidimensional and multisystemic alternatives, (4) providing thematic focus and consistency throughout treatment, (5) prompting behavior change, (6) evaluating, with the family and extrafamilial others, the ongoing success of interventions, and (7) revising interventions as necessary.

10. **The therapist's attitude is fundamental to success.** Therapists are advocates for adolescents *and* parents. They are neither child savers nor unidimensional "tough love" proponents. Therapists are optimistic but not naive or Pollyannaish about change. Their sensitivity to environmental or societal influences stimulates ideas about interventions rather than reasons for why problems began or excuses for why change is not occurring. As instruments of change, therapists know that their personal functioning can facilitate or handicap their work.

Basic Requirements for Clinics Offering MDFT

Treatment Locale

Most sessions (individual sessions with adolescents and parents, sessions with parents and adolescents together, and sessions with other family members or relevant extrafamilial persons) are conducted in the clinic. On occasion, particularly at the beginning of treatment or during a crisis, sessions might be held in the family's home or at another accessible, appropriate locale (school, family court). The clinical contact location also may vary according to the phase of treatment, the living circumstances and preferences of youth and families, and the session's objectives.

While the MDFT approach has been used only in clinical research contexts, these efforts have taken place in various settings such as community mental health, drug counseling, or youth service agencies. In some studies, clinics were located in the community in which the study clients resided. In other studies, the project was conducted in existing clinics where the randomized study, the selection of the therapists (from existing staff), the pretreatment assessments, the experimental treatments, and the posttreatment assessments were conducted within the agency context.

Treatment Duration and Intensity

Studies have tested variations in duration and intensity of treatment (Liddle & Hogue, 2001). The CYT study called for delivery of the intervention in a 3-month period. For the initial 2 months, an average of two or three sessions with various combinations of family members could be held weekly (sessions averaged 1 to 2 hours). Phone contact was frequent and used for reviewing and planning for next steps. Phone contacts also presented opportunities for "minisessions" or focused conversations that served to motivate, to hold in place, or to make new suggestions about how to cope or new courses of action. The most frequent contact with family members occurred during the first 2 months of therapy. In the third month of treatment, the amount of contact decreased.

Nature of Clinical Contact

In MDFT, phone contact with the parent and the adolescent is frequent and moves beyond reminder calls. MDFT therapists use time on the phone to follow up, extend the work done in sessions, and conduct troubleshooting on what is being tried at home and how it is going. In MDFT, the therapist has face-to-face or phone contact with extrafamilial systems such as school, juvenile justice, or case management-related personnel (e.g., academic tutoring, job training). Contact with extrafamilial subsystems is often more frequent at the beginning of therapy, tapering off as the case reaches the final treatment phase. In all situations, the amount of clinical contact occurring will vary according to the stage and module in which the family and therapist are working.

Staffing Requirements

Most therapists using the MDFT approach have at least a master's-level degree in counseling and an average of 2 to 3 years of experience (master's degree therapists at 70 percent; doctoral-level therapists at 30 percent).

Certain characteristics are sought in clinicians who will be trained to use the MDFT model. First, a family therapy background and systems orientation are helpful. The multisystemic model, which clearly includes a basis in family or systems therapy concepts and methods, is taught in the context of this orientation. Clinicians must be willing to conduct case manager-style interventions along with traditional therapeutic interventions. Previous experience with drug-using and delinquent adolescents is desirable as well. Preferred personal characteristics include intellectual curiosity, a capacity to work in different domains (cognitive, affective, and behavioral), an ability to form good personal relationships, and an openness to receiving feedback about one's personal clinical style. Finally, a clinician's demonstrated motivation to become an exceptional therapist (and the realization that this achievement takes years of focused work and experience) is one of the most powerful predictors of success with the MDFT system. Therapist characteristics and skills helpful to the MDFT approach are discussed in publications on clinical supervision and training (Liddle, 1988; Liddle, Becker & Diamond, 1997).

Clinical Supervision Requirements

Clinical supervision is vitally important in the implementation of the MDFT approach. The multidimensionality of the therapeutic orientation is matched in the supervision philosophy and methodology. Multiple supervision methods are used in a coordinated way to produce the desired level of adherence and clinical competence. Therapists prepare written case conceptualizations and segments of videotape or audiotape for presentation and analysis by the supervisor and feedback from other clinicians. Therapists review their own taped work, and they are assigned to continually study the MDFT manual and related clinical materials. As the competencies and learning needs and issues of therapists become manifest, supervisors adjust their supervision and teaching.

Therapists are expected to take considerable responsibility for their continued learning and development, although individual and group supervision is provided. Individual supervision allows focus on sensitive topics (e.g., personal or stylistic matters of clinician development), as well as an individualized focus on the standard review of weekly outcomes, adjustment of strategy or method, and planning of next steps (Liddle, Becker & Diamond, 1997).

Overview: The Three Stages of the MDFT Treatment Program

This section summarizes the key activities in each therapy stage. Detailed implementation guidelines, examples, and troubleshooting tips on making these procedures work appear throughout the manual.

Stage One: Build the Foundation (3 weeks)

1. **Create a new system.** Treatment creates a new social system. When the process works, it joins together the therapeutic system and the family system to create a new entity with a common purpose. Thinking organizationally, therapists strive to understand the many systems and subsystems involved in the treatment process and the nature of their past and current interactions.

2. **Welcome the adolescent and the family to a new life space.** Starting treatment is a big event. Many outpatient treatment programs do not place sufficient emphasis on the beginning stage of treatment or on the process of welcoming teens and their parents and engaging them in a treatment program. Clinicians know that treatment of adolescents is challenging, and research confirms that more teens and their parents

drop out of outpatient drug therapy than remain. The beginning phase of treatment, when a therapist does all that he or she can to help all family members feel welcome and understood, is of enormous importance.

3. **Explain the program.** Do not assume that parents or adolescents will have a positive or accurate perception of treatment. An orientation to the program or treatment that covers "how to benefit from therapy" and "what the treatment entails" is vital. The mindset of family and extrafamilial sources of influence about the new treatment can be addressed by asking about previous treatment experiences or, in the case of the extrafamilial persons, asking about their history with the youth and experiences with other treatment programs. Expectations are important, and they can be shaped.

4. **Address the circumstances that bring the client into treatment.** Many teens will be referred to treatment by school or juvenile justice personnel. Some of these adolescents will have serious legal problems and will be ordered to treatment as a condition of their probation or involvement with the juvenile justice system or because of their problems in school. It is important to address the specific circumstances that bring them into the program. Therapists should look for points of cooperation and resistance and develop a positive realistic conception about what treatment is and what it might be able to do.

5. **Develop a temporal orientation.** In this 3-month version of MDFT, not all the interesting or important issues that will be presented can be addressed. Therapists must choose which focal areas might have the most clinical yield (e.g., which seem most malleable and which areas are accessible immediately). MDFT intervention has a fixed number of weeks in which the program will be delivered. Thus, prioritizing treatment focuses is critical. A 3-month calendar in the case notes will remind therapists of the strict timelines within which they must work.

6. **Remember, intensive involvement is the norm.** Because the available time to work with a case is predetermined, remembering the therapeutic principle of intensive involvement with a case is critically important. With some cases, particularly at the beginning of treatment, there may be in-person or phone contact with one or more persons in the treatment system (e.g., the adolescent, parent, or other family members; school, legal, court, or probation staff) every day. A core premise of the approach is that positive outcomes will be related to working effectively in several areas (modules) of a case at the same time.

7. **Use current crises to mobilize positive forces and create focus.** Pioneers in MDFT's earliest development of structural family therapy (Minuchin, 1974) and problem solving therapy (Haley, 1976; see Liddle, 1984, 1985) understood how important it is to seize opportunities presented by current crises pertaining to the adolescent. School failure, conflict in the home, out-of-home placements, and consequences of current drug use, including arrests and legal problems, are examples of crises with potentially enormous therapeutic value. Inherent in these

events are the information and opportunity to create a workable (i.e., acceptable to the client, potentially effective according to the approach) therapeutic focus and the kind of step-by-step change that can last.

8. **Use distress to facilitate motivation.** The distress that accompanies a crisis is a therapeutic ally. It is part of the dynamic that will create motivation for change. Even if no crisis is present, distress, which is perhaps different for each family member and relevant extrafamilial others, is present. The subjective distress of each family member should be accessed; framed, if necessary; amplified; and used to create a foundation and motivation for treatment.

9. **Translate therapy goals into an organized and orchestrated treatment that yields various kinds of sessions (individual, familial, extrafamilial).** Although the term family therapy is still used, today's family therapies are better defined as *family-based* treatments. The term "family therapy" creates an image of working with the whole family, week after week. MDFT is a therapy of systems and subsystems. A hallmark of this approach is its theory-grounded and systematic use of individual, familial, and extrafamilial sessions. Different therapy stage and subsystem-specific therapeutic goals dictate a therapist's decision about session composition. (See Guidelines for Subsystem Sessions on page 177 for more details about setting up individual and family sessions.) Therapy goals are formulated according to a number of factors. Case-specific treatment is theory based (i.e., development) and principle driven. (See Principles of Multidimensional Family Therapy on page 14.)

10. **Create expectations.** Negativity, hopelessness, helplessness, and despair frequently accompany adolescents and their parents to treatment. At the outset and as needed throughout therapy, treatment addresses these powerful emotions. It is important to create expectations that the teen's life course can be redirected, new alternatives can be introduced, the drug-taking lifestyle can stop, family life can change, and parents' stress and burden can be lessened.

11. **Elicit and shape the stories.** A therapist's skill is revealed when he or she uses generic knowledge about family life, positive psychosocial development, and problem solving as a way to make sense of the idiosyncratic details of a teenager's and his or her parents' lives. The therapist facilitates this process by eliciting details about the teen's life, the parents' lives, and the family's life together. The developmental issues of adolescence (e.g., a teen's desire to be heard) are the immediate context in which the teenager's and parents' expression of their life story occurs. At the same time, the family's history together is also relevant and must be explored as well.

12. **Work multisystemically.** Classical family therapy assumed that changing a family's interactional style and patterns would yield changes in the symptomatic functioning of the child or adolescent. Contemporary family models do not reject the importance of interactional change in

the family, but today's models do place this focus as one among many. MDFT therapists pay attention to the individual, intrapersonal functioning of family members and to how important sources of influence that come from outside the family complement and work synergistically to change family interactional patterns (Liddle, 1995). Working with multiple systems in a coordinated way, inside and outside the family, is fundamental to MDFT.

13. **Talk with everybody (family and extrafamilial persons).** There are advantages and disadvantages to doing a treatment program within a fixed period. A major advantage is that time can be used to focus on and organize the therapist's and family's mindset ("We have only so much time available") about getting something done. At the same time, working in a time-limited model can influence therapists to narrow their focal areas and targets of change. It is important to be aware of the interplay of the pressure to create a workable focus (which may enhance motivation) with the inclination to expend energy and time trying to include family members or extrafamilial persons in treatment. Phone calls to important therapeutic system members serve various functions. They are strategic, in that they might prepare individuals for a new focus, and functional, in the sense of providing a convenient context for interventions themselves.

14. **Build multiple alliances.** In the beginning of treatment, key concerns are whom to develop alliances with and how to accomplish this time-consuming, challenging task. Each person within and outside the family is treated as an individual who has his or her own idea about topics important to treatment—the need for therapy, who is the problem, how the problem came about, and how it might be solved. This may be an obvious point, but the mandate of success in multiple therapeutic alliances, including those with relevant persons outside the family, is more difficult to implement than to understand.

15. **Use treatment to retrack development.** The developmental lens guides every aspect of assessment and intervention. MDFT therapists are developmentalists. Minuchin (1982) warned that therapists who work with the most challenging clinical situations have an occupational hazard—they can, unwittingly, become sleuths for psychopathology or family dysfunction. Searching for individual, family, and community strengths is a critical aspect of MDFT. Accentuation of these resources is the antidote to the pessimism that frequently pervades the teen's and his or her family's lives. Knowing about the developmental tasks for adolescents, parents, and family balances the assessment of "what's gone wrong" with the instigation of processes that retrack the development of all family members.

16. **Work the phone.** The concept of a *session* does not have the same meaning as it once did. Therapists think more in terms of *therapeutic contact*, and variations of contact, with clients (and their multiple constituents inside and outside the family). Telephone work is a critical part of this therapy approach. More than serving as reminders ("I was

just calling to remind you about our session tomorrow"), phone calls to family members are opportunities to give important new information that may not have been available or offered in a face-to-face session. They are also valuable opportunities to follow up on previous events or interventions. Phone calls serve an intervention function with extrafamilial persons as well. Interventions are thought of in a more broad-based way than they were previously. They do not require face-to-face contact, nor do they have to occur within the confines of an office or a traditionally defined session.

17. **Craft themes.** Good therapy focuses on events and circumstances that have personal meaning to each participant. Although themes materialize or become apparent through content, they exist at a level different from the content that is revealed in the retelling of life events or discussion of everyday events. A theme in a therapeutic context represents a recurring part of reality; it is a different kind of "truth." Themes point to a consistency in or repetition of events, feelings, or outcomes of relationships; a summary statement; or a characterization of a relationship's core nature. These characterizations of past relationships or events can also be used as a reference point for future, hoped-for relationships or life themes.

18. **Visit the school and neighborhood.** Particularly if he or she is not accustomed to doing such things, a therapist will sometimes avoid school visits and neighborhood assessments early in therapy. However, the establishment of therapeutic alliances (not exclusively with family members) is a critical early-stage accomplishment in this treatment. The MDFT protocol includes school contact and neighborhood visits throughout treatment. This reflects commitment to an *ecosystemic assessment and intervention* philosophy. The information obtained by a visit to a school, neighborhood, or juvenile justice system setting (e.g., family court, probation officer meeting) is critical to initial case formulation and to the implementation of a comprehensive multicomponent intervention. Changes in drug use will be related to changes in the real world circumstances of the teen. It is not possible to intervene directly in all aspects of the adolescent's environment. At the same time, it is vital to know as much as possible about all those corners of teen and family life.

19. **Test different pathways and kinds of change.** MDFT assumes that multiple pathways and kinds of change are possible; such combinations may be necessary to change firmly entrenched drug-using lifestyles. Many teens have lived in less than optimally functioning families and developmental circumstances for years. Because important assessment information comes from the feedback received after intervention, early-stage therapy probes for receptivity, for the pathways and kinds of change that may be available, and for which ones may be more sealed off, at least temporarily.

Stage Two: Prompt Action and Change by Working the Themes (5 weeks)

1. **Develop from the foundation.** Setting a treatment foundation involves the articulation of themes. There may be several, and they may relate to individuals, subsystems in the family, the family as a whole, or its extrafamilial influences and forces. Themes create reference points for the treatment. These reference points induce consistency and continuity. Focusing themes and working change strategies (enactment, individual emotion processing or regulation, or problem-solving work) facilitate the processes and circumstances that can reverse and provide concrete alternatives to a teenager's drug-using and problem-behavior lifestyle.

2. **Mobilize the troops: Therapeutic leadership.** Whereas treatment's first phase offers beginning experiments in change, in the second stage of therapy the therapist mobilizes various systems, including self-systems (i.e., individuals), and articulates the stakes involved (i.e., often a life-or-death situation for a teenager). The therapist counters the forces (e.g., pessimism in the family; dysfunctional beliefs and attitudes about drugs; influential, deviant peer culture) that perpetuate the interacting and often escalating negative outcomes. Barriers to change can combine to produce a legacy of failure and development gone wrong, a legacy made up of powerful, things-cannot-change feelings, thoughts, and behaviors.

3. **Increase action and change orientation.** Whereas mobilization works in the realm of emotion, increases in action and change orientation use the focused emotions to prompt new and consistent planning and action. Therapists must show a fierce commitment to the possibilities of change and communicate this commitment to the family and involved extrafamilial others, in every contact with the teenager, parents, and extrafamilial others to avoid a slide toward greater deviance and build connections to prosocial pursuits and developmental adaptation. Establishing concrete alternatives to drug use and the drug-using lifestyle (e.g., school and academic skills, general equivalency diploma [GED] alternatives, confronting legal problems, and options to disaffiliate with deviant peers) helps clients fight despair.

4. **Think successive approximations.** Shaping is a behavioral psychology principle, a step-by-step approach to change. The change process is conceptualized sequentially (affective, cognitive, and/or behavioral elements may be present and applicable). In assessing the multiple developmental ecologies of teens, therapists ask, "What are the missing aspects of the teenager's and family's lives? What set of circumstances and what specific day-to-day activities and intrapersonal and interpersonal processes could reverse the current development-destroying circumstances?" These questions, asked in individual, family, and extrafamilial sessions, begin a change process. They are small steps that facilitate materialization of the missing and developmentally needed processes or behaviors.

Once these new behavioral forms, emotions, or adaptive thoughts emerge, they are helped to grow. Gradually, they are coaxed out and made large in conversations that make the experiments in change real. Change in one area is often used as a prelude to or a foundation for changes in more difficult or challenging areas. For example, change in a parent's emotional reactions to a son or daughter prepares the parent for changes in actual parenting practices (G.S. Diamond & Liddle, 1996; Liddle, 1995; Schmidt, Liddle & Dakof, 1996). A changed emotional set or response to one's teen makes a focus on behavioral parenting strategies possible.

5. **Work with the most accessible areas first.** The first stage of therapy involves determining areas of the parents' and teenager's lives that will be most accessible. These will not be the only available areas or necessarily remain available. In the second stage of treatment, the therapist is more consistently in an action-prompting mode to confront avoidance and inaction through alternative-oriented plans that attempt to create new intrapersonal, interpersonal, and contextual circumstances.

6. **Link available focus areas to less accessible ones.** MDFT therapists think in terms of direct and indirect pathways to achieve a goal. The available focal areas may often be the very pathways that link to work in areas that were previously unavailable. The adolescent's drug use is a primary case in point. Many teenagers deny their drug use and do not accept an agenda to work on it during the first phase of treatment. With these adolescents, a therapist tries to establish other focal areas of treatment (e.g., problems with school or parents, legal difficulties, unhappiness with life) and uses these accessible areas as routes toward what the teen has closed off from the therapist and others. Many teenagers, for example, become willing to talk about drug use and other problems in a straightforward way if the therapist is willing to do (or actually does) something concrete for them (e.g., intervenes at school, with probation, in family court). Process research confirms that, even in situations in which there is an initially poor therapeutic alliance, certain therapist methods change a negative alliance to a positive one (Diamond et al., 1999).

   Getting a teen to focus on drug use in outpatient treatment can be a challenge. Drug tests during therapy quickly move the therapy to a place where drug taking and/or the consequences of drug use and abuse, such as legal problems, can be addressed. (See Clinical Guidelines: Dealing With Drugs in MDFT on page 70.) Additionally, using the available leverage and pressure issued by legal or school authorities may be a therapist's best course of action at the outset of a case.

7. **Make theme development more rich.** When topics and areas of work are woven together, they become rich in definition and meaning. Asking for deeper levels of details about the themes and linking previously separate events enable a therapist to develop themes that are more meaningful to the adolescent or parent. Focusing on life themes

(such as a conclusion about one's life at a particular time) and the emotions that accompany them can be a motivating force. The direction for new and future actions can be inherent in that. Using themes as a reference point in therapy provides a focus, including a focus on the day-to-day changes that are the local pathway out of current circumstances.

8. **Think and work in all modules.** A multidimensional model implies working in a number of realms simultaneously. It is possible to focus on core themes, keep these areas primary during the middle phase of therapy, and check in and work minimally in other areas. Certainly time limitations, caseloads, and accessibility may hinder this principle's implementation with any given client. But a multidimensional model of change requires a multidimensional intervention methodology. This necessitates the therapist's not allowing his or her therapeutic focus, particularly in the middle stage of treatment, to become so concentrated on one area of work that other important areas are ignored. This principle works with number 7. The therapist must focus on important areas of work and, at the same time, be in a position to incorporate other focuses if needed. The therapist's sound judgment allows this dialectic to stay fluid and productive.

9. **Storyboard it: Think in stages.** The idea of stages also applies to smaller units of work. Thinking in terms of *stages in a session* can facilitate goals for any given meeting or treatment session. Preparing for a session by breaking it up into parts requires clear thinking and careful planning. Using storyboards (visual scripts) in therapy is a way to visualize the steps that might be involved in facilitating a particular in-session (short-term) outcome (Liddle, 1982).

   A session in the middle phase of treatment is often conceived of as a three-act play (plot and story development, conflict, resolution). The first act sets the stage. Individual sessions with a parent or teenager may determine the agenda and develop the details that will be worked out in a joint session. The second act, the middle of the session, may involve an attempt to address issues that have been unresolved in a face-to-face joint session (parents and teenager). Therapists try to create an appropriate environment to help family members improve the way in which these issues have been addressed thus far. The goal is concrete progress in addressing these issues in a reasonable, step-by-step manner (a positive step in and of itself if they are addressed in adaptive ways) (G.S. Diamond & Liddle, 1996, 1999). Again, thinking in phases, the third part of the session may involve an intentional closing up of the work for that day, an attempt to create a certain cognitive frame around these events, and setting the stage for the next attempt at moving the relationships and issues along. This may occur between sessions or at the next formal session (in the home or in the clinic). The storyboard is a session plan that flows directly from the case conceptualization; it has continuity with the therapist and family's previous work together. A typical middle-stage session is articulated before the session starts in the imagination of the therapist and supervisor.

10. **Think of crises, slips, and detours as opportunities.** Experienced therapists know that crises, slips, and detours are usable. Crises are used to refocus and request even more effort from the involved adults. A teenager's relapse or slip demands attention; perhaps the intervention needs to be recalibrated. A detour may indicate that the direction and strategy are faulty and need immediate rerouting or adjustment (Liddle, 1985). Perhaps, roadblocks are being created by extrafamilial people unwilling to give the teenager another chance. All these situations require creativity and a nonreactive mindset about unpredictable events. Important information is being conveyed in the unanticipated or negative therapeutic event; it is important to craft a response that maximizes the chance that the event can be used therapeutically and as an opportunity to take further steps toward needed change.

11. **Use family enactment.** Enactment is the art of helping a family have a new kind of conversation about what are usually difficult topics (prompting and shaping new kinds of interactions). Enactments happen spontaneously in family interviews and can be seen when a family demonstrates, through conversation, an aspect of its interactional problems right in the session (interactions of family members are consistent, and, in the context of therapy, as elsewhere, these patterns show themselves). The therapist tries to instigate interaction because interaction is a manifestation of the relationships that are, in part, related to the creation and perpetuation of problems. Thus, family interaction is one target of change, and developmental knowledge guides and informs enactment.

    Enactment refers to theoretical principles about the change process (including prompting or shaping of new behaviors) and active therapeutic methods to prompt change (actions to foster new kinds of dialog about important topics). The middle phase of therapy is the one in which enactment is given significant play.

    Enactment is difficult for most therapists—it raises the emotional temperature in sessions and sometimes prompts the displeasure of a family member toward the therapist. Therapists must overcome their fear of setting up and creating enactments. Knowing enactment allows the therapist to conduct a fully multifaceted and orchestrated set of interventions.

12. **Work the sequence: Receptivity, skills, opportunity and context, practice, introduction of variation, generalizing.** A therapist should conceive of a *sequence of interaction* between two or more persons as a unit of a broader context of interaction and interactors. These interactional sequences break old relational molds and create what Minuchin (1974) called new relationship realities. Attention to the small details of individual reactions in a sequence often provides clues for how to shape the interactional sequence (Diamond & Liddle, 1999; Liddle, 1995).

13. **Work the core sessions (think domains, people, and topics).** Although there are core aspects to MDFT treatment, MDFT is not run on a programmed, session-by-session basis. Treatment is organized according to modules. For example, the therapist aims to help each parent in that individual's parenting role *and* personal life. The rationale is that changes in parenting practices lead to improved functioning and well-being in nonparental realms. With teenagers, it is necessary to specify areas of developmental need and make these areas important treatment focuses (examples are identity development, psychosocial competence, and balancing autonomy with connectedness to family). The developmental knowledge bases mentioned previously can help determine what the core treatment emphases ought to be.

    The therapist asks, "What actions need to be taken or can be taken to create alternative experiences and new organization in this adolescent's and family's lives that counter the previous deviance- and drug-related lifestyle patterns?" A sense of "What's missing in this picture?" thus applies to interaction in a session as well as to sequences or courses of action (generating alternatives) that prompt action outside sessions (e.g., school intervention, increased monitoring, change in family routines).

Stage Three: Seal the Changes and Exit (4 weeks)

1. **Remember that time is an important treatment dimension.** Because the treatment program is delivered in 3 months, the therapist's every action must be guided by time.

2. **Make an honest appraisal of current status.** The treatment's final phase, especially in this relatively short-term, time-limited version, depends on a brutally frank estimation of what has and has not been accomplished in treatment. The therapist should seek a "good-enough" focus and determine which core change targets will be sufficient to create immediate and (it is hoped) lasting change. Change includes avoiding a slide toward greater dysfunction, gravitating toward deviant peers, and deepening disaffiliation with school and other important social institutions, including the youth's family. Altering the trajectory of and pull toward greater deviance by making sure that problem behaviors do not become more severe can be a major accomplishment in itself.

3. **Accept "rough-around-the-edges" outcomes.** Rough-around-the-edges is a phrased used to describe potential perfectionism or standards about changes that may be too high (on the therapist's part). Its connotation is that it is helpful for the therapists to be mindful of the difficulties of any kind of change attempt and of the dangers in holding a teen or family to too high a standard. It is not yet known which kinds of changes (e.g., changes in peer status, family changes, changes in individual skills or competence) are the most influential mediators of bottom-line outcomes such as drug use and abuse, but even a partial change may be sufficient. Abstinence and the development of an

alternative to the drug-using and drug-abusing lifestyle of the teen are an unequivocal goal of MDFT.

4. **Emphasize and make overt the changes in any and all domains.** The therapist's exit is the client's new beginning: The family and extrafamilial others remain. One important aspect of the final phase of therapy includes establishing meaning for the changes that have occurred and putting into words some of the changes that may yet have to be made (i.e., constructing bridges to still-needed changes). It is important to emphasize that family members have each other and, it is hoped, other sources of support and guidance as well. The specific successes and accomplishments of therapy are discussed and used as evidence of and prompts about how new crises or problems will be handled. The family's new skills are used to help them exit from the treatment program. An emphasis is placed on the adolescent's continued orientation toward self-care, development, and health, including his or her involvement in prosocial activities, and the family's capacity to support continued progress—facing normal developmental tasks.

5. **Assess next steps and future needs.** Needing future services is not thought of as a sign of failure. Recall that a teenager and his or her family have completed a 3-month treatment.

Although treatment occurs in 12 weeks in MDFT, it is important to keep the following points in mind:

1. **Method is a variable, and so is time.** A critical dimension in the CYT study was the amount of time that was available to see a teenager and his or her family. The amount of time is a given and presents an interesting scientific and intellectual dimension on which to evaluate treatment.

2. **Look beyond once-a-week therapy.** Although there is a fixed period of time within which the therapy must be delivered, there is flexibility about how much time can be spent with the case during the 12 weeks. Certainly caseloads and a family's receptivity to an intensive model (an undeveloped area of clinical research) will affect how much time a therapist can spend on each case per week.

3. **Look beyond "in-the-room" treatment.** Another critical barrier that must be overcome to consider this treatment a true ecological therapy is where the services will be provided. Just as "sessions" have an expanded meaning (e.g., some occur on the phone), expansions of how much therapy occurs (beyond once a week) and where it occurs are critical for the therapist to understand.

Modules Are Intervention Targets

Four focal areas (or modules), each of which is a primary developmental arena, organize treatment: (1) adolescents, (2) parents and other family members, (3) family interactional patterns, and (4) extrafamilial systems of influence. The adolescent focus includes the adolescent and his or her peer world. The parent focus includes parents (biological, step) and parent figures (informal or unofficial caretakers) and other family members and extended family who may or may not live nearby. Family interaction concerns the transactional system made up of the parents, family, and adolescent. Extrafamilial focuses include significant others and other systems external to the family.

Whole and Part Thinking

The multiple ecologies in which teenagers reside are both wholes and parts (see whole and part thinking in Appendix A. Key Terms and Abbreviations). While functioning as "whole" biopsychosocial units, families are also part of and influenced by other systems of input and organization. A therapist's job is to understand each system or ecology (family, school, peer, community) as *both* a whole *and* a part and to devise interventions that fit this conceptual framework. Interventions target processes within subsystems as well as processes that are happening or need to happen between subsystems as well.

Multiple Domains of Simultaneous Intervention

What are the interventional implications of this perspective? Each of the four modules has aspects that could be understood as distinct from the others. Together, they represent the adolescent's psychosocial world. Each area is one of the multiple "locales" in which assessment and intervention occur. These domains reflect organizational units in which risk and dysfunction-producing processes occur. They could also be considered the multiple pathways to follow to activate different versions of change or to instigate changes in one area with stage-specific processes in mind. The primary treatment goal is to alter development of the adolescent and his or her social context in a way that establishes healthy socialization and development. If adolescent drug abuse is a manifestation of a particular lifestyle (Newcomb & Bentler, 1989), then it is the lifestyle that needs to change.

Interventions are a series of small steps that occur sequentially, partly by design and partly according to feedback recalibrated or revised in microsequential human interactions (Liddle, 1985) moving toward positive outcomes in various functional domains.

Each MDFT module—adolescent, parent, parent–adolescent interactions and extended family, and extrafamilial systems (Liddle, 1999)—is critical to the change process. Each contributes to the creation and continuation of the drug taking and related problem behaviors, as well as to the possibilities of changing the life course to turn it away from the developmental detours of drugs and delinquency. The modules relate to empirically established areas of risk and protection for youth and families, as well as to knowledge about how adolescent drug abuse and related problem behaviors begin, continue, expand, or end.

Interventions With an Adolescent

Establishing a therapeutic alliance with a teenager is distinct from a similar effort with a parent. It is critical to establishing the foundation of treatment and creating circumstances under which treatment can progress (G.M. Diamond & Liddle, 1996; Schmidt, Liddle & Dakof, 1996). Just as there are developmental tasks in life, so there are developmental stages in therapy. This first-stage work is called adolescent engagement interventions (AEIs), which include:

- Presenting therapy as a collaborative process
- Defining therapeutic goals that are meaningful to the adolescent
- Generating hope by focusing on the adolescent's internal locus of control and by presenting oneself as an ally
- Attending to the adolescent's experience (Diamond et al., 1999).

Diamond and colleagues (1999) demonstrated how initially poor therapist–adolescent alliances can be improved.

Alliance-building interventions occur in both individual and family sessions (Liddle, 1995). It is important for therapists to understand the need for (and inevitability of) different therapeutic alliances with each family member. Therapeutic alliances also exist with outside systems. Adolescents must be made to feel that the treatment program can meet some of their needs and that they can gain something by coming to treatment (Liddle, Dakof & Diamond, 1991). Research has revealed that a focused and systematic use of certain cultural themes (e.g., the journey from boyhood to manhood) enhances early-phase engagement as well as the middle-phase work with adolescents. (See The Adolescent Subsystem Module on page 54 [Jackson-Gilfort et al., 2001].) Although the field is still learning about similarities and differences between male and female adolescent drug abusers (Jainchill, Bhattacharya & Yagelka, 1995), MDFT has begun to articulate gender-sensitive strategies for formulating and addressing the unique needs of female drug users within the context of family-based treatment (Dakof, 2000).

The therapist helps teenagers learn how to (1) learn more about their feelings and their thinking patterns, (2) communicate effectively with parents and others, (3) effectively solve social problems, (4) control their anger and impulses, and (5) gain social competence. Much of the work consists of preparing parents and adolescents in individual sessions so that they can come together in joint sessions to talk about issues that have meaning for them. Individual time with adolescents is used to develop alternatives to impulsive and destructive coping behaviors such as drug and alcohol use. Achieving therapeutic objectives with the adolescent requires the therapist to contextualize interventions designed to enhance social and life skills in the peer culture and address the influence of life on the streets. The therapist is systematic and detail oriented in pursuit of the facts of street life as well as of the adolescent's perception of that life and its consequences for his or her future. In this way, the therapist facilitates the process of engaging the adolescent with prosocial peer influences and positive familial influences.

Interventions With Parents and Other Family Members

Interventions with parents

The primary objective of MDFT is to reconfigure the drug-using and deviance-prone lifestyle of the teenager with a replacement lifestyle, literally a new way of being in the world. This new way of living is characterized by more prosocial pursuits, including a more adaptive and active connection with institutions of socialization that keep the teen from continued deviance and easy access to drug-using and delinquent peers. This involves retracking the teen's development.

An adolescent's symptoms may be related to outside factors and forces. MDFT intervenes multisystemically with many different forces in the teen's life, and the adolescent's parents are a source of influence. MDFT has a stepwise way of reaching parents. This procedure parallels the sequenced way teens are reached in the first phase of therapy. Parenting relationship interventions (PRIs) (e.g., enhancing feelings of love and commitment, validating parents' past efforts, acknowledging difficult past and present circumstances, generating hope by increasing parents' internal locus of control, generating hope by presenting the therapist as an ally to the parents) were designed to close the emotional distance between the parents and adolescent (Liddle et al., 1998). These can enhance parents' individual functioning and, in turn, enhance their motivation and willingness to try a new kind of relationship with and parenting strategies for their adolescent.

Damaged or disrupted attachment relations are linked not only to adolescent dysfunction (Allen, Hauser & Borman-Spurrell, 1996) but also to impaired parental functioning (Hauser, Powers & Noam, 1991). The ultimate aim of PRIs is to increase parents' commitment and involvement with their adolescent, even with an adolescent who has abused drugs and is seriously involved in criminal activities (Schmidt, Liddle & Dakof, 1996). Therapists then foster parenting competency by supporting consistent and age-appropriate limit setting and regular monitoring of school attendance, school performance, and other activities.

Interventions with other family members

Although work with the adolescent drug abuser and his parents is central to MDFT, the approach recognizes that other family members often play key roles in drug taking and maladaptive patterns of teenagers. Siblings, adult friends of parents, and extended family members are taken into account during assessment and interventions. Individuals who play key roles in the teen's life are invited to participate in family sessions, or sessions are held with these individuals alone. Cooperation is achieved by stressing the serious circumstances the youth is facing at the time of therapy (e.g., school expulsion, arrest, juvenile court problems) and the need for all significant others (particularly adults) who can influence the adolescent to join forces in an organized, alternative-seeking manner.

Interventions To Change the Parent–Adolescent Interaction

Once the therapeutic foundation is successfully established with adolescents and parents through therapeutic alliances, explaining the treatment program, beginning the process of formulating goals with the parents and teen separately, and increasing parental involvement with the adolescent, the therapist requests direct change in the parent–adolescent relationship. Enactment is the foundation for facilitating change in the relationship domain (G.S. Diamond & Liddle, 1996, 1999). Although the parent–adolescent relationship is a focal topic with both the parents and the teen individually, it is in joint interviews that the relationship can be observed and assessed directly and the interaction between parents and teen shaped.

Historically, a fundamental aspect of all family-based interventions has been targeting theory-specific dysfunctional family interactions, which were associated with the development and continuation of problem behaviors. Although contemporary family-based models may include many other targets, assessing and trying to change family interactions remains important. These problem interactions may be (1) current manifestations of problems that began as developmental struggles (e.g., increasing independence for the teen), (2) problems that have grown or evolved over time (e.g., noncompliance, school problems, affiliation with deviant peers, drug use and delinquency, legal problems, and family disengagement and despair), or (3) events such as family crises (chronic or acute) or traumas (e.g., parental substance abuse, physical or sexual abuse, physical abandonment). Studies have illustrated how changes in family interactional patterns are related to changes in the symptomatic behavior of children and adolescents (e.g., Alexander et al., 1983; Mann et al., 1990; Robbins et al., 1996; Szapocznik et al., 1989), including changes in the in-session behavior of drug-abusing teens (G.S. Diamond & Liddle, 1996; Schmidt, Liddle & Dakof, 1996).

An early marker of progress in the parent and adolescent relationship is how discussions are handled. Initially, the basic focus is on a "first things first" philosophy. Therapists work on basic communication skills and patterns (see Bolton, 1979). For instance, can the parents and adolescents state their points of view? Can they listen and indicate that they heard the other's point of view? Excessive blame, defensiveness, and recrimination are characteristics of early-stage conversations and indications of the troubles that the relationship has seen.

Therapists understand that a session or any discussion creates a context. Over time, new experiences of the other individuals and of the self, as well as the new outcomes from the new kinds of conversations, contribute to new relational outcomes. When parents and their adolescents come together and relate in new ways, the adolescents become more confident and competent in expressing their needs and addressing their responsibilities and parents become less likely to abdicate their roles as parents and more likely to provide support, which serve as a buffer against the adolescent's involvement in substances and deviant peer groups. Family relationships can change; changed family relationships, manifested in new emotions being expressed and new interactional patterns, contribute to reductions in adolescent symptoms and gains in prosocial behavior.

Interventions With Systems External to the Family

MDFT targets multiple realms and aspects of the adolescent's functioning for change. The family has not been found sufficient to create or maintain change in all cases, particularly when the teen's and/or parents' level of functional impairment is high. When external forces conspire against change or adoption of prosocial competencies, the need for well-organized and integrated multisystem work becomes acute. Multisystem interventions, including those that resemble case management, are therapeutic, particularly when coordinated with individual and family interventions.

Common examples of multisystem interventions include the following:

- If a parent is overwhelmed, help in negotiating complex bureaucracies or in obtaining needed adjunct services may be critical.
- Parents may need help in obtaining services related to housing and medical care coverage.
- The teen may need help with transportation to job training or self-help programs.

A high level of collaborative involvement is promoted among all the systems to which an adolescent is connected (e.g., school, work, tutoring, job-training programs, juvenile justice appointments). When the adolescent is involved with the juvenile justice system, intensive working relationships are swiftly established with the probation officer or other court staff connected to the adolescent. Therapists also routinely meet with school personnel for case consultation and to help the school understand the treatment and its focus on school attendance and performance. Work with the family and the adolescent alone focuses on devising plans for improving the teen's school-related behavior (i.e., removing obstructions to school attendance and improved performance). Other interventions may include promoting consistent monitoring by institutions and advocating for the adolescent's special educational needs.

Therapeutic Case Management

Practical tips for integrating therapeutic case management activities into an overall intervention plan are listed in Table 1. Therapists should maintain a current file of all available resources in the region and the names and numbers of the appropriate contact persons. Therapeutic case management provides wraparound services that allow the adolescent and family to receive solid, practical support while they learn to function differently. These interventions also can stabilize a family in crisis and keep the teen and family in the treatment program.

Table 1. Procurement and Organization of Resource Information

Outside Tasks

1. Research all resources in the geographic area that would be useful to the MDFT treatment model:
   - A. *Schools*—Multidisciplinary teams, alternative schools, GED programs, tutoring programs, vocational and technical schools, etc.
   - B. *Jobs*—Job training, vocational education, etc.
   - C. *Prosocial Support*—Mentoring, park and athletic programs, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), parent groups, afterschool activities, psychoeducational workshops, etc.
   - D. *Economics*—County and/or city social services, State and Federal economic services (Aid to Families with Dependent Children, Supplemental Security Income, Temporary Assistance for Needy Families, etc.), emergency food, shelters, charities, housing programs, U.S. Department of Housing and Urban Development programs, etc.
   - E. *Medical*—Medicaid, Medicare, medical and dental programs, drug prescription services, optometrist and eyeglass services, family planning, etc.
   - F. *Other*—Court programs, police department programs, juvenile justice and probation procedures, the Immigration and Naturalization Service (INS), etc.
2. Meet with resources to determine their appropriateness, gather direct information on their use, and make contacts. Visit sites, tour facilities (including detention centers), and meet staff.
3. Regularly update the resource file and contacts.

	Case Management Tasks	Related Therapeutic Tasks
Schools	1. Monitor attendance of those clients who attend school daily. 2. Compile attendance and in-school behavior (suspensions, detentions, etc.) records monthly. 3. Pick up school records. 4. Monitor parental receipt of and signatures on all school reports and forms (e.g., report cards, interim progress reports, weekly/daily progress reports).	1. Assess client needs. 2. Assist in curriculum planning. 3. Advocate for the client with the school system. 4. Assist parents in processing interactions with the school system. 5. Educate parents about the school system; enable them to affect the process. 6. Discuss interventions and outcomes with the client.

Table 1 (continued). Procurement and Organization of Resource Information

	Case Management Tasks	Related Therapeutic Tasks
	5. Attend school meetings and conferences and multidisciplinary team meetings. 6. Maintain active contacts with schools, alternative education programs, etc. 7. Monitor contact and progress with tutors.	
Jobs	1. Make referrals to appropriate agencies. 2. Take the client (parent or adolescent) to appointments at job agencies, to vocational education, or to interviews.	1. Assess client needs. 2. Discuss interventions and outcomes with the client.
Pro-social Support	1. Monitor attendance at all prosocial activities. 2. Take clients to 12-Step meetings and record all meetings. 3. Facilitate parental access to support groups and/or 12-Step meetings as necessary. 4. Evaluate the appropriateness of recreational activities in terms of content, staff competence, and rapport. 5. Determine costs, hours, and attendance requirements. 6. Take the client to meet staff and enroll him or her in activities. 7. Accompany client to activities as necessary. 8. Facilitate and monitor mentor contact. 9. Conduct nightly and weekend check-ins by phone.	1. Assess client needs and interests. 2. Determine which activities are most appropriate for the client. 3. Determine whether an increase or decrease in attendance at activities is necessary. 4. Discuss interventions and outcomes with the client.

Table 1 (continued). Procurement and Organization of Resource Information

	Case Management Tasks	Related Therapeutic Tasks
Economics	1. Facilitate access to all available monetary services. 2. Take clients to apply for and obtain services as necessary. 3. Maintain updated contacts with providers.	1. Assess client needs. 2. Set up a plan with the client to determine how to best meet his or her needs. 3. Attend meetings with service providers when the client's behavior has affected receipt of services. 4. Discuss interventions and outcomes with the client.
Medical	1. Facilitate healthcare service access. 2. Make referrals to or appointments with appropriate services. 3. Take family members to appointments with healthcare providers as necessary. 4. Obtain reports or results from providers as necessary. 5. Visit family members at inpatient facilities when appropriate.	1. Assess client needs. 2. Confer with medical professionals about the client's health needs, particularly with psychiatrists about medication. 3. Implement human immunodeficiency virus (HIV) intervention. 4. Discuss interventions and outcomes with the client.
Other	1. Make referrals to appropriate programs. 2. Maintain contact with juvenile probation officer. 3. Conduct daily check-ins with the client about conditions of probation. 4. Attend court hearings as needed. 5. Visit the client in detention as necessary. 6. Take family members to INS appointments as necessary. 7. Take the client to appointments.	1. Assess client needs. 2. Advocate for the client when appropriate. 3. Make court appearances when necessary AND when the attorney's agenda fits in with therapeutic plan. 4. Discuss interventions and outcomes with the client.

Sample narrative. It is important to orient the adolescent and family to the MDFT treatment program. Explain to the parents and adolescent the practical focus on extrafamilial systems and activities. The following excerpt comes from a first session and illustrates how therapists typically explain the program's extrafamilial focus.

Therapist: [to Mrs. Jones and Willis] *Part of what we're trying to do is to find out the different sides to every story.*

[to mother] *Are there things that you're not happy with? Are there things that you want to see him doing? You had hopes for him, dreams for him.*

[to adolescent] *Willis, part of what I will do is to get to know you a little bit, to get to know where you stand on some things, what you'd like to see change, and I'll try to help you find a way to deal with things in a way that works better for you and for your mom, too.*

[to both] *Our program gets involved with the social workers at probation. I know Miss S. [social worker]. I'll be calling her to say that Willis is in our program. I will keep connected with her and keep tabs on what is happening there.*

If there are problems in the school, I will get involved there as well. I always like to let them know we're on the scene, we're working on the same team really, trying to get things right for Willis. Sometimes kids have had trouble in school, and it's helpful if we're able to go to bat for them a little bit. We might say, "Could you slow things down? Don't kick this kid out; we're trying to stop the slide—we're trying to do something good here."

What I'm saying is that there are some things outside this room that I get involved with. So I'd like to encourage you to call me between our meetings and say, "this or that happened" or "the school called." If something comes up at home, if there's an argument—a problem—either of you can call me. It's not just when you're here, but I'm thinking about these things all the time. Don't forget that I'll be in touch with other people who are involved with your situation, too. So I wanted you to be aware of that part of our program.

Today is our first meeting and it's real important for me to find out from you, Mrs. Jones, and from you, Willis, what's going on with each of you. Can I meet separately with each of you now? Then we'll all come back together at the end of our time today.

III. MDFT Sessions: Operational Features of the Approach

The Three Stages of Treatment: An Indepth View

MDFT treatment unfolds in phases, but like all stage models, it has variation and overlap between the stages.

Stage One: Build the Foundation

The early work of therapy involves establishing an alliance with both teens and parents. These are distinct relationships, with their own courses, expectations, and contracts for what therapy can and will be. Success with one in no way guarantees success with the other. The alliance between therapist and parent, for instance, does not necessarily predict an equal working relationship between a therapist and teenager. An effective therapist–parent relationship may, in fact, lead to difficulties in the therapist–teenager alliance. MDFT thus goes to great lengths to ensure that excessive focus on parental issues does not transform *family* therapy into *parent* therapy.

Adolescents are able to discuss some, but certainly not all, aspects of their lives with their parents. They remain in contact with a healthy, vital peer network and sphere of activities. The therapist connects and at times translates the parents' and adolescent's experience with each other. Seeing the adolescent and parents separately throughout therapy accentuates this function.

However, the instigation of these engagement and reconnection processes is no small feat, given the degree of often longstanding emotional distance, disenchantment, and hostility evident in these families (Burke & Weir, 1978; Mann et al., 1990). Living in environments such as these exacts a severe psychological price (Rook, 1984). A critical step in reconnecting the parents and adolescent occurs at the outset of therapy. Without success in this area, the therapist's efforts at relationship repair often remain incomplete. This challenging therapeutic task depends on the engagement of the teenager in treatment.

Engaging the adolescent

At the outset, the teenager is helped to feel that therapy can address his or her concerns. The adolescent is assisted in formulating personal thoughts and feelings about his or her life and family and over time is helped to express some of them to his or her parents. In the beginning phase of MDFT, the therapist helps the teenager articulate a different agenda from that of his or her parents. (See Adolescent Engagement Interventions on page 62.)

Key Concept:

Alliance building begins with demonstrating genuine interest in and commitment to the adolescent's well-being.

These adolescents commonly feel disrespected and abused and believe themselves to be hardly worth listening to. Most often they are told to "just listen and be quiet." Many people such as members of their families, school personnel, and probation officials have agreed on the undesirability of the teenager's behavior and/or personality. MDFT aims to create a new experience for the adolescent, one in keeping with some of the most basic elements of any counseling relationship. Alliance building assumes genuine interest in and commitment to the adolescent's well-being. Presenting the possibility of a relationship in which the teen will be cared about, respected, and listened to is a basic first step of engagement. For an adolescent to be successfully included in family therapy, the therapist must believe that it is important to elicit the teenager's story and, further, that it is in everyone's best interest to attend to the teenager's needs and complaints. This module suggests a way of engendering such collaboration.

Setting a foundation is crucial. What follows enumerates key aspects of the therapist's message. More detailed transcript versions of this approach are available elsewhere (Liddle et al., 1992). The messages contained in the sample sentences *(italics)* in this module are intended to stimulate a discussion with the adolescent.

This therapy is for you, too.
Adolescents enter therapy under various circumstances, most of which deter engagement. The wise therapist (i.e., one who is interested in including the teenager in treatment) is one who immediately and successfully addresses a common teenage lament: that therapy cannot help them and that therapy is simply something their parents want.

I can and will be on your side at least some of the time.
This works as an alliance-building theme. Family therapy with adolescents necessitates multiple alliances, all of which need constant attention. Teenagers are often surprised by the therapist's genuine interest, respect, and support.

It is possible that your parents do not understand you.
By bringing this content into the therapy, the therapist establishes the need for parental understanding of their adolescent's feelings.

They may not know enough about who you are, who you are becoming, what your life is about, and what your interests and ambitions are.
The interpersonal and social context of the teenager's experience is vital. Troubled adolescents often feel alienated from their parents, indeed from life itself (Harlow, Newcomb & Bentler, 1986; Newcomb & Bentler, 1988).

Some aspects of who you are will always remain private (we can talk about this between us if you like), but it is important for your parents to know about some of what is going on with you.

Therapists should be sensitive to teenagers' boundaries, especially those pertaining to information that they may want to keep private. Acknowledging this is critical. Therapy must be a place where the teenager not only can express himself or herself but also can be heard.

Adolescent development literature has long recognized identity formation and development as important tasks for teenagers (Erikson, 1968) but only recently has documented their intimate connection to positive family relations (e.g., Grotevant & Cooper, 1986; Hauser et al., 1984; Youniss & Smollar, 1985). Thus, indepth knowledge of adolescent development guides a clinician's thinking and behavior. This aspect of the module also connects the adolescent's recognition of problems in his or her life to those in the family.

When your parents understand you and know you more fully, they can appreciate what you are going through [e.g., adolescent transitions, resentments about the past].

The interpersonal or social aspect of the adolescent's experience continues and is made more complex by discussing the parents' response. Parents are not the only family members who feel hopeless about change. Teenagers frequently manifest their hopelessness by not believing their parents can behave differently toward them. It is important to address the parents' lack of response to the teenager in the past while being positive about the possibility of change.

When your parents begin to understand your experience, it may be possible for them to change the way they interact with you. I will help them with this.

MDFT assumes that families can be better and that parents can do a more effective job of raising their teenagers and caring for everyone's needs. Therapists are bound by an ethical code as well as a code of good sense not to make false promises in therapy; nevertheless, it is imperative to be a spokesperson for change. This is especially critical with teenagers and their parents, who frequently have had years of shared failure and pain and who have often been told by outside agents that their child or teenager is beyond help.

I can help them with the sort of change they need; this is between me and them (e.g., your parents can treat you better, or their marital problems are not for you to get caught up in; leave that to me).

The adolescent worries that no matter what he or she does, his or her parents cannot change toward him or her. The therapist must anticipate the teenager's realization that not every change should be up to him or her. The therapeutic agenda is defined as a mutual struggle to deal with the necessary transformations in family relations (Hill, 1980). Another aspect of this situation concerns clients with pressing marital problems. Here, the therapist reassures the teenager that although he or she knows full well the marital troubles that may be occurring, these matters will be between the therapist and the parents. The therapist informs the teenager that nothing should interfere with the goal of helping the teenager's parents "be better parents."

But, to do all of this, they have to get reacquainted with you. You have to let them know more directly and in a more effective [i.e., age appropriate] *manner what's going on with you. This will be tough because you are burned out on them (and perhaps they are with you, too), but I can help you get better at telling them about what's going on. You'll have to trust me with that. All this will take time.*
The therapist acknowledges the hurt feelings and lack of motivation as understandable reactions to past failures and hurts and current resentments; it is imperative to deal directly with past trauma (Liddle, Dakof & Diamond, 1991). At the same time, therapy is defined as an opportunity to start over, or at least make the best of the current situation.

Let me know who you are, express that stuff to me (as a prelude to expressing it and working on it with them).
Meeting alone with the teen, the therapist first works to help the adolescent clarify his or her thoughts, feelings, and experiences. Premature attempts at problem solving can escalate into negative emotion among family members, which has been found to have deleterious effects on attempts at problem solving (Forgatch, 1989). Gradually, the individual sessions allow the teenager to practice a new "language," that is, how to discuss sensitive topics with his or her parents in a constructive way.

I assume that you have some valid gripes about your parents and maybe about life in general. But I also assume that the way you have been going about telling your parents and the world about all of this has not gotten the right message through. You'll want to get angry at them and maybe blame them for the way you feel, but for now, I want you to just try to tell them how you are thinking and feeling about yourself and your life.
The adolescent is challenged to be a participant in shaping the way his or her parents behave. The teenager's feelings and experiences are validated but his or her methods are not. Revealing the adolescent in new ways can change the parents' viewpoint and the helplessness and lack of control they often feel (Newcomb & Harlow, 1986). This is intended to counter the teenager's sense that "Therapy is for my parents, not for me."

These thematic keys play a significant role in establishing an alliance with a teen. Working these themes early in the treatment (either in the presence of the entire family or with the teen alone) sets a foundation for engagement.

Engaging parents

During the same period, the therapist sees the parents alone. Assessing and adjusting the emotional connection of the parents to their teen is usually the first order of business in working with tired, helpless, angry, and intimidated parents. Eventually, therapists help parents define their parental belief system and preferred parental styles, paying close attention to the developmental aspects of their ideas. Adolescent identity development that is fostered through a continued familial interdependence rather than emotional separation (Grotevant & Cooper, 1983) and the influence of different parenting styles on adolescent personality are interwoven here. For example, a parent might be told, "Your son does need you to talk to him about his concerns and worries. You can be the best medicine in the world for him." Interdependence and the necessity of both parents and adolescents negotiating the youngster's transition to adulthood (Steinberg, 1991) become content themes and goals of the therapy. Therapists emphasize the themes of emotional depletion, hopelessness, anger, and the urgent need for parental action.

Parental belief systems (Goodnow, 1988; Sigel, 1985) become important topics of discussion with parents. These themes help parents cooperate with one another and build the parental coalition long considered important by family therapists (Minuchin, 1974). Parents are coached, and their belief systems (Sameroff & Feil, 1984) are explored and, if necessary, reformulated to rekindle the parental imperative (the state of mind in which parents are energized and motivated to try again). The main mechanism for such influence resides in establishing a new, developmentally appropriate relationship. This relationship is one that has successfully negotiated the requisite parent–adolescent transition (Steinberg, 1999).

Families of drug-abusing adolescents must make these efforts in the context of their own relationship history. The therapist and parents discuss the barriers to relationship repair and reconnection and attend to and accept the parents' many feelings about what has happened with their child. Through these discussions, parents begin to feel the therapist's support and understanding, and the therapist attempts to facilitate renewed parental hope and commitment toward their adolescent. Therapists are mindful of motivation and a practical language and focus that places the treatment in a developmental framework.

The following statements *(italics)* illustrate the parental module's content.

> *It wasn't easy for you. You've been on your own since he was born, raising him on your own. What I hear you saying is that you feel alone in this. It was a bad, hard situation for you.*
> The therapist acknowledges the difficult past and present circumstances that impede parenting and family management practices and acknowledges that the parent has individual problems, disappointments, desires, hopes, and dreams. The parent is provided validation that he or she has a life separate from the parent role.

I know this is frustrating for you. But I have to disagree with some of what you are saying. You can follow through. I remember the time he stayed away from home for a few days and nights, and you went to the place where he was staying and dragged him out of there. If that's not followthrough, then what is?
It is vitally important to search for and confirm examples of successful parenting behaviors and to validate the abilities that exist.

So why are we doing this (coming to therapy, trying to reach out to your child)? You're doing this because you love her and you're concerned about her. It tears you apart, and that's why you're here.
Therapists try to actualize the parents' experience and feelings of love, caring, and commitment toward the adolescent through past feelings of love, joy, aspiration, and pride in the adolescent. This includes focused recollections of rewarding parenting experiences from earlier developmental periods and small pleasures that occurred in the recent past.

Is that really why you're so mad? I think you're just talking about the superficial stuff. I want to know what makes this so hard. What's getting in the way of you two working out day-to-day problems? Why is there so much anger and resentment?
The therapist attempts to bring out important events, core issues, or themes, then facilitates serious emotional discussion of these issues, which may lead to forgiveness. It should be an honest discussion of feelings, responsibility taking, and listening, not blaming and denial.

We're trying to move you out of that rut of being on the run, almost saying, "He'll get us because we didn't say this." No, he doesn't have to get you, because you're the parents.
Parents often feel hopeless. The therapist combats the parents' belief that the adolescent is not in need of or is beyond parental influence. The therapist must be unequivocal in stating the need for the parents to stand by their teenager.

I've seen how tough this is. My heart goes out to you, and I will do everything I can to support you.
The therapist presents himself or herself as an ally who will support the parents in their attempts to influence the adolescent. This is critical to addressing the fundamental dilemma of hopelessness about change.

These themes play a significant role in engaging parents in treatment and in adolescent–parent relationship recalibration. The improvement of concrete parenting skills may then rest on this foundation.

Stage Two: Work the Themes

Key themes

The second stage consists of getting and keeping the right content in therapy, as well as facilitating processes and fostering skills that allow this to occur by working and reworking MDFT themes that constitute the family's core struggles. Examples include:

- Parental frustration ("I can't take this anymore.")
- Parental helplessness ("There is nothing I can do.")
- Parental fear of setting expectations ("I don't want trouble.")
- Parental abdication ("I give up.")
- Parental meaninglessness, mastery and control, competence and influence, respect, and love and commitment
- Adolescent entitlement ("You can't tell me what to do.")
- Adolescent rejection of parental authority and hierarchy ("We are all equal.")
- Adolescent and parental hopelessness ("Things will never get better.")
- Negative adolescent perceptions ("I can never get a break.")

These key themes will be addressed and expanded on throughout the manual.

Therapist guidelines in working the themes

Therapists use these themes as a roadmap to barriers to positive development and keep in mind several theoretical tenets that help orient the working of the themes:

- Adolescent development research guides therapy.
- There needs to be a renegotiation of the adolescent's and parents' transition through the establishment of modes of interdependence (versus leaving home or separation-only goals).
- Although they transform to meet the adolescent's developmental needs, attachment relations remain important throughout adolescence.
- In the therapeutic alliance, alliances are formed with multiple family members and influential others outside the family as well.

- Affective themes such as hopelessness and despair are blocks to skills training and problem solving.
- The therapist's use of self is important in establishing a commitment to the teenager and family's well-being.
- The treatment program must be practically oriented and careful to move beyond a control, power, and authority therapy.
- It is important to understand the influence processes of parents and peers (careful of antifamily or peer reductionism).
- The therapist and parents should adopt and foster a "do what it takes" philosophy.
- By the time a teen appears at a treatment program's doorstep, the negative processes in which he or she is involved have often evolved and multiplied. Therapists generally work to counter extreme responses or all-or-nothing solutions.
- Sessions with parents and the teenager have objectives and intended outcomes, in and of themselves, and the work in any given session may be a precursor to future work, focus, or objectives (i.e., they are both a whole and a part of other therapeutic work).
- Life cannot be perfect, and therapy outcomes might be less than perfect. Therapists should be careful of any tendency toward a "cure" or an emphasis on perfect treatment objectives.

Dealing with the past in a present-centered therapy

The MDFT model deals with past hurts and trauma in the lives of teenagers and families. The therapist who wants to do effective work with adolescents and families must not bypass the disillusionment, anger, and despair that many teenagers and their parents bring with them from the past.

Entering the terrain of the past with parents and teenagers can serve therapists well if they can use this content to further therapeutic aims in the present (Liddle, 1994a). A family's memories include past dreams and hopes that need to be reclaimed. The ability to talk together about hurtful past events removes obstacles to dialog in the present. Negative emotions, often related to past events, are the major impediment to problem solving in the present.

In the following exchange, an adolescent shares his feelings of hurt and abandonment and his fear, as a child, that he might never see his mother again when she went out drinking. Interestingly, he makes a connection between his fears for her safety in the past and her fears for his safety in the current situation.

Willis: *When I was young, sometimes I had fun. I always had fun when my mom was around me, but I used to be scared when she would leave me and go out to the bar and drink. I was scared she might not come back. Now, she goes and does that when I go out—she's scared, she don't know if I'm gonna come back or not. I used to play outside, and she used to go out Saturday nights. I used to cry, and I didn't think she would come back home. And I used to always come outside early on Sunday and sit on the step,'cause the bus stopped right on the corner. And I used to be so proud when she used to get off that bus.*

Therapists must assess what makes the greatest contributions to emotional impasses in current family relationships. Therapists must, if necessary, prepare family members who will have the most difficulty dealing with the past by holding individual discussions with them. (See Guidelines for Subsystem Sessions on page 177.) The therapist might say to a parent, "Your son has a lot of feelings about what happened in the house 5 or 6 years ago when you were in your addiction. It might be hard for you to hear from him about this. Can we talk about what might come up for you?" During the conversations themselves, the therapist must ensure that individuals are not talking in a detached or remote way about these events but are able to attach feeling to the recounting of them; it is emotion that can engender the kind of interpersonal exchanges that can lead to change in behavior and perception (Liddle, 1994a).

Stage Three: Seal the Changes and Exit

Key Concept:

Change is expected on many fronts. Does the adolescent demonstrate improved judgment, relationships? Has his or her drug use stopped or been greatly diminished? Is he or she able to problem solve and avoid escalation of troublesome encounters with others? Is he or she in school, working? Has the family process of handling difficult situations increased the likelihood of problem resolution? The therapist looks for multiple confirmations that there has been significant fundamental change.

The third and final phase consists of working to (1) keep progress shored up, (2) let the family do its own work, and (3) emphasize generalizability, transfer, and extension of the new ideas and behaviors to current and future situations.

In this phase, the therapist refines any other issues that the family needs to address. Change is expected on many fronts. Is the teen in school? Has the adolescent's drug use stopped or been greatly diminished? Is he or she able to solve problems and avoid escalation of troublesome encounters with others? Is the teen still hanging out with drug-using friends? Has the family process of handling difficult situations changed in a way that increases the likelihood of problem resolution? The applicability of the family's new attitudes and skills to a variety of situations is emphasized.

The therapist may help family members articulate the ways in which their beliefs about each other have changed (as well as some that have stayed the same). Parents typically attribute the teenager's behavior and actions to normal processes rather than psychopathology. The therapist might have the family reminisce about a particularly difficult crisis point in the therapy, one in which members persevered and negotiated through to a solution together. The therapist also might review the problem-solving strategies that have been learned during therapy as well as discuss some of the key events on which they were used to seal the changes that have occurred and help the family see that each member has contributed significantly to the treatment's outcome.

IV. Goals, Rationale, and Procedures of MDFT Interventions

Key Concepts of MDFT Interventions

- Multidimensionality
- Redefining sessions
- Multiple therapeutic alliances
- Linking
- Continuity
- Whole–part [holon] thinking
- Doing what it takes
- "Parental hell"
- Working all four corners
- What you don't know CAN hurt you
- Organizing according to modules and stages
- Goals and themes emerge from the interaction of the generic and the idiosyncratic
- Culturally sensitive treatment

Multidimensionality

Adolescent problems arise in many ways and for different reasons. Serious drug problems do not appear overnight. Change in MDFT is ambitious and complex. It involves understanding the individual's functioning as well as the mechanisms of interconnection among the various levels and kinds of systems that affect a teen's life (as well as factors that have been active over time but are no longer apparent).

Multidimensionality is a mindset, a way of thinking about human problems and their resolution to discourage narrow or reductionistic thinking about clinical problems or solutions. Therapists are taught to understand the many systems that are involved in the continuance of drug and behavior problems. They probe to understand the events, personal and family characteristics, and circumstances that over time have led to the current situation in which the teen uses drugs, does poorly in school, has legal problems, is connected to deviant peers, and is disconnected from his or her family.

Multidimensionality refers to case conceptualization, notions about causality, and ideas about how lives can change for the better. Multidimensional thinking reminds a therapist not to overplay or be overly reliant on one pathway, means, or technique to facilitate change. Solving a teen's drug problems involves changing many things that currently support drug use, including his or her individual attitudes and beliefs, individual developmental (prosocial, identity-oriented issues; self-efficacy) issues, affiliation with and access to deviant peers, failure with and disconnection from prosocial institutions (school and religious affiliation), the family environment (which may include the mental health issues of a parent), and parenting practices.

Therefore, the therapist's assessment, conceptualization, therapeutic strategies, and intended outcomes are, in one sense, all the same—they are all multidimensional.

Redefining Sessions

Various treatment parameters have been reexamined in the MDFT approach. There is experimentation with more intensive and extensive versions of MDFT treatment, using the approach with a therapist and therapist's assistant in some studies and, in others, accessing families by meeting with youth and families not only in clinics but also in homes. Another aspect of rethinking some basic therapy aspects concerns phone calls. Once seen in the category of "reminders" to come to sessions, phone calls are now used as sessions themselves. Hence, this is one way to redefine the concept of a session. Meeting with the adolescent and family in detention while waiting for a teen's hearing at drug court or meeting an adolescent at a restaurant or movie are ways to continue to gain access to a case. The venue—the session context—changes to provide maximum flexibility and an opportunity to implement the program's principles and clinical methods.

Multiple Therapeutic Alliances

The therapeutic alliance in individual treatment has a longstanding and solid theoretical and, increasingly, research-based history. MDFT requires several therapeutic alliances—presenting a challenge to successful MDFT. As is the case in the development of multiple constituencies of any sort, in the process of developing multiple therapeutic alliances, different motivation levels and intentions about the youth and treatment will become apparent. At the same time, the therapist, as one who is a competent navigator of multiple subsystems in the family and systems outside the family, begins and facilitates the progression of these multiple relationships simultaneously. Everything focuses on the youth's needs and treatment—how the teen's life course can be directed away from drug use and deviant peers and toward prosocial, developmentally appropriate pursuits. Therapists are aware of and skilled in applying different kinds of competencies needed with teens, parents, other family members, and school and juvenile justice officials.

Linking

Linking is the process of molding and shaping changes across functional domains in different developmental environments (school, family, self) over time. Linking is a method through which therapeutic continuity can be achieved. Change is multiply determined and requires the connection of in-session content themes and accomplishments across sessions. There is a *successive approximations* or a *building block* approach to change. Linking also applies what has happened in the therapy session to future challenges, generalizing gains made in therapy to different areas of the teen's and family's lives. It also involves highlighting the progress made by one family member to motivate and facilitate change in other family members.

Continuity

Emotional, behavioral, and interactional changes are initiated and maintained in systematic steps throughout treatment. Continuity of the therapeutic work is maximized through strategic planning and constant recalibration based on assessment of outcomes. Whereas the foundation between the therapist and the teen, family, and extrafamilial sources of influence is laid in the early stages of therapy, continuity is the goal of the middle stages. Continuity is achieved by working and reworking themes via in-session behavioral enactment and out-of-session tasks. Later stages of therapy involve consolidation of themes and therapeutic gains across sessions (e.g., cognitive sealing, affective recollections, behavioral troubleshooting, refinement).

Whole–Part (Holon) Thinking

The focal areas of MDFT are each considered to be a holon—both a whole and a part. An individual is a "whole" biopsychosocial organism as well as a "part" of other systems such as families, work, peers, community, and ethnic or racial group systems. Systems, both intrapersonal and interpersonal, are interconnected and mutually influencing. An important job of the therapist is to acquire an understanding of how each system works as both a whole and a part and to devise appropriate interventions.

Doing What It Takes

Another mindset concept, "doing what it takes," refers to a clinician's attitude as much as it refers to any specific technique or piece of behavior. The doing-what-it-takes attitude is not only something a therapist strives to develop; it is also something that is conveyed to the youth and family. By the time a teen is referred to MDFT, many problems have occurred. Generally, they have been in existence for some time. Pessimism may be the primary emotional tone in the family and in those social systems that know the youth. This emotional tone influences current and future activity (or, all too frequently, inactivity) relative to the youth's situation. The doing-what-it-takes stance announces a no-more-business-as-usual approach to the adolescent's situation. It emphasizes that a life is at stake, and, indeed, other lives in the family are at stake as well. Therapists carry through on this approach: they cannot announce a high degree of commitment to obtaining outcomes and pursuing all possibilities for change with the teen and family and then fail to deliver. MDFT is not for therapists who are faint of heart. MDFT works with therapists to help them adopt this doing-what-it-takes attitude—a therapeutic position about what is needed to facilitate change in lives that have been overcome and immobilized with failure and that have an absence of options for escape from a developing and deepening lifestyle of deviance and antisocial activity.

"Parental Hell"

MDFT teaches therapists to be active and directive about prompting change in all system members. But the timing and nature of this stance toward change and growth vary. It is important in working with parents and teens to understand what they have been through. Just as work with the teen moves through phases, treatment in the parental subsystem is phasic as well. One of the first things to do with parents is to understand their world, to appreciate what they have been through with the teen. Families are disrupted—indeed, torn apart—by a teen's drug problems. Parental shame and embarrassment and a sense of deep failure are powerful emotions that many parents in studies have lived with and felt for many years. Parents frequently tell therapists that their adolescent has "put them through hell." Therapists have listened to this oft-heard exclamation and have become committed to understanding all that goes into a conclusion of this magnitude. Therapists thus try to understand the hell that the parent has been in or is in. Although the parents may have participated in creating their self-defined parental hell, this systemic reality cannot be confused with the necessity for the therapist to first find a way to support each family member and each person outside the family who might be involved in the youth's life at the moment (e.g., school and juvenile justice personnel). So the concept of parental hell is meant to remind therapists of the intensity that a teen's problems can create with family members and of the need to first understand the disappointment, pain, and anger that the adult/parent on the scene may feel. With parents of clinically referred teens, the first job is to visit with them the personal parental hell that they have been to or are experiencing. It is from this place that requests for changing their parenting can come (Liddle et al., 1998).

Working All Four Corners

Because MDFT aims to facilitate individual and synergistic change processes in multiple realms of functioning, it is important to have a way to define the areas in which history and current functioning should be assessed and the areas in which change should be worked. "Working all four corners" refers to the assessment and facilitation of change in four areas—the adolescent, the parents, the family transactional environment, and the youth and family vis-à-vis community and extrafamilial sources of influence. This concept works with multidimensionality in the sense that the four corners idea names the multiple realms a therapist must first understand and in which the therapist tries to facilitate change.

What You Don't Know CAN Hurt You

This maxim, paraphrasing "what you don't know can't hurt you," reminds the therapist that a comprehensive assessment is vitally important and that a therapist's knowledge of local resources, policies, and procedures about important parts of family life is fundamental to success. Therapists who wish to advocate for their teens and families must be knowledgeable about such things as court hearings and proceedings and school regulations regarding testing, tutoring, expulsion, alternative school options, and so on.

Organizing According to Modules and Stages

Modules refer to (1) areas or realms of therapy, (2) different bodies of knowledge, (3) intervention locales, and (4) pathways to and mechanisms of change. MDFT consists of four modules: (1) the adolescent module (therapy related to individual work with the adolescent), (2) the parent module (therapy related to individual or conjoint work with parents, parental figures, or guardians), (3) the family interaction module (therapy related to familial work and the assessment or alteration of relationships and interactions), and (4) the extrafamilial subsystem module (therapy related to work with any system in the adolescent's or parent's social world). Each area is one of several targets for assessment, intervention, and change. Change is conceived in stages, which are necessary to achieve successful outcomes. Attempts to implement problem solving in relationships, without achieving developmentally appropriate levels of attachment and communication, will not be successful.

Goals and Themes Emerge From the Interaction of the Generic and the Idiosyncratic

Therapeutic goals and content themes in treatment are the by-products of an interaction between two spheres. Generic factors relate to issues such as how families operate, the risk and protective factors involved in substance abuse, and the developmental tasks of all early versus late adolescents, for example. Idiosyncratic factors refer to the particular set of individual circumstances, events, and personalities and history that have come together and evolved over time to produce this particular youth and family. Generic refers to universal laws of adolescent development and the development of dysfunction, whereas idiosyncratic refers to characteristics and processes that have worked and continue to work together to give an individual and his or her family identity.

A therapist uses his or her universal or generic content knowledge as a guide for getting to know the youth and family and as a framework to assess areas of high and low functioning. It is in the interaction of this generic knowledge and the youth's and family's responses, their own particular stories, that the goals and core content of treatment are born. Clinicians enter treatment with teens with ideas and a knowledge base about how teens and families develop and how dysfunction begins and becomes exacerbated. Yet the therapist does not know what competencies or problems exist in a particular family, in particular lives. The generic content of their lives offers the framework or scaffolding on which the idiosyncrasies that are in front of the therapist can be explored and fleshed out. Once this unfolding and revealing occur, the particular needs of people involved in the case are evident. When needs of the youth and family are evident, then it is a straightforward task to specify the goals. It is in these multiple and interlocking stories, and also in the therapist's process of organizing and assimilating them, that treatment's core focuses reside. Life and relationship themes come from the content of the stories about what has happened in the lives of the teen and family. Therapists develop a way of listening to content that culls redundancy and repetition and identifies "big picture" meanings and implications.

Culturally Sensitive Treatment

Racial and cultural issues are taken into account in tailoring interventions to each adolescent and family. Culturally sensitive treatment emphasizes (1) the therapist's activity within multiple systems of the adolescent's life, (2) the facilitation of active client involvement in treatment, (3) the use of popular culture, and (4) the extensive discussion of salient cultural themes and the use of these cultural themes to elicit life stories, life plans, and revelations about important past events. Based on the information the therapist gains, he or she then can exert positive influence on socialization and involve prosocial adults as mentors.

The Adolescent Subsystem Module

Goals

- Build a therapeutic alliance with the adolescent
- Create a collaborative agenda
- Establish a developmental–ecological framework of treatment
- Improve functioning in several developmental domains
- Transform a drug-using lifestyle into a developmentally normal lifestyle
- Facilitate developmentally adaptive competence in multiple settings.

Rationale

Adolescent drug use and abuse are multidimensional phenomena and, thus, multiple aspects of the teenager's biopsychosocial ecologies must be addressed if treatment is to be transformative.

Procedures

- Meet alone with the adolescent.
- Assess the biopsychosocial ecologies of the adolescent.
- Assess competence in key areas of development.
- Assess and address multiple life skills.
- Foster self-examination and appraisal.
- Facilitate communicating thoughts and experiencing feelings about important aspects of life.

- Organize opportunities for the adolescent to explore and address these issues in important interpersonal contexts (family, school, work, peer systems).
- Create prosocial, developmentally appropriate, and facilitative alternatives to the drug-using lifestyle.
- Address drug use directly through drug counseling techniques such as functional analyses of drug use, getting details about the "people, places, and things."

Adolescent drug abuse has different clinical presentations—different "looks." Adolescents may be engaged in more violent behavior than drug use or might be extensively involved in drug use and engage only intermittently in delinquent activities (Loeber, 1988). Broad descriptive terms such as "delinquent" or "adolescent drug abuser," if not misleading, certainly are not helpful for clinical work. The complexity of adolescent drug abuse cases is illustrated in the following vignette. The therapist intended to draw the teen out and help him clarify and articulate his life experiences.

This excerpt from a conversation between the therapist (T) and Alonso (A) reveals a teen who has experienced quite a bit in his 13 years.

> **T:** *So here's a little boy who's 7 years old, he doesn't speak English, he comes to this city, he doesn't know what's going on, he meets both his parents—never met 'em before, lives in a bunch of different neighborhoods. Boy, that was a lot.*
> **A:** *Yeah, but...*
> **T:** *How easy do you think that was for a little boy?*
> **A:** *To me it was easier than it shoulda been, because I didn't really know the mother and father routine. All I knew was they said, "Go here, go there." I didn't grow up with my mom. I didn't get taught no lessons or nuttin'.*
> **T:** *At the time you said didn't know any better, right? But you look back on it now and say, man, that was a lot.*
> **A:** *Yeah.*
> **T:** *You said, "The mother and father routine." What is that?*
> **A:** *You know, you live, you grow up with your mother and father, and they teach you right from wrong and the do's and don'ts. You know, I didn't grow up like that. They ain't ever teach me no right 'n' wrong. All I know is when I did some bad, I catched a whuppin, and when I did some good, I kept it to myself. You know what I'm saying?*
> **T:** *Nobody ever told you when you did something good?*
> **A:** *Right.*
> **T:** *Come on, really?*
> **A:** *Nobody didn't care.*
> **T:** *What about your aunt that died?*
> A: *She used to beat me when I did some bad, too. Yeah, but that was sort of like to help me out, 'cause that was like teaching me right and wrong. You know what I saying? "Don't do that." Then whoosh.*

T: *Right, okay, so maybe she was trying in her way.*
A: *Mm hmm* [nodding].
T: *What about your stepmom?*
A: *My stepmom, now she wouldn't really see me do nuttin' good, but she ain't never whup me. Oh, you know, "He's a nice kid."*
T: *You think she loved you?*
A: *Yeah, I know she loved me.*
T: *Okay.*
[later in the session]
A: *I remember when I was a kid I used to be like, damn, they did drug dealing, you know, that's real bad.*
T: *Mm hmm, yeah.*
A: *But then I started doing that when I was like 12 years old.*
T: *Mm hmm.*
A: *So that does, that did, have an influence on me.*
[later in session]
A: *So I was like truant. Well, that was when I started smoking cigarettes, and smoking weed, when I was in like the fifth grade. I was 10 years old.*
T: *Where'd you get the weed?*
A: *Check this out. In the Meadows, there's the rich part, there's the Chico part, and the black part. Well, I used to stay in the Chico part. But I had a cousin who lived in the black part, so I walked to his house. My cousin was older than me. He was like 13; I was around 9 or 10. And all the people he'd hang with was older than him. And all of them smoke weed. And I started smoking weed, and I didn't used to tell nobody 'cause I thought it was bad—"Oh, he smoke weed; it's bad."*
T: *It is bad.*
A: *Yeah* [laughs], *but I started smoking cigarettes too, 'cause I used to always see my mom smoking. And I'd get sick in the stomach. Then I started smoking weed. Now, when I was little, my stepmom, I be seeing them drink, and my brother he would sneak a beer. And he'd be like, "Oh let's sip some of this." I didn't know what it was, glug glug, and it didn't really get me drunk back then. But when I started drinking, that's when I started getting drunk and stuff, you know. But back then I used to just drink, and they'd be, "Oh, don't drink that bomb," and they'd take it from me. And I'd be like, "Why'd you take it from me?"*
T: *And how old were you then?*
A: *I was like 8.*

A drug and assessment screening instrument (e.g., Global Appraisal of Individual Needs [GAIN] [Dennis, 1999] or Problem Oriented Screening Instrument for Teenagers [POSIT] [Rahdert, 1990]) can be used in treatment. These self-report scales provide a quick assessment of the teenager's life and help identify desired changes.

Suitable change is defined as a decrease in or stopping of drug use and other correlated problem behaviors, as well as the creation of or an increase in developmentally appropriate competence in family, peer, and school relationships (Masten & Coatsworth, 1998).

Research on families gives therapists considerable understanding of the kinds of parent–adolescent interactions (i.e., processes) that are related to positive and negative developmental outcomes. This knowledge guides construction of interventions that block negative interactions (Diamond & Liddle, 1999; Liddle et al., 1998) and amplify existing but hidden strengths (Schmidt, Liddle & Dakof, 1996).

Particular kinds of change (e.g., creating willingness to reflect on one's current life circumstances) facilitated in a preferred sequence may be necessary before other kinds of change (e.g., creating a willingness to talk with one's parents about these feelings) are possible (Haley, 1976; Howard et al., 1993; Miller & Hester, 1986).

The engagement phase with the teenager is devoted to specifying a personally meaningful agenda—a reason for participating in treatment that may or may not coincide with the agendas set by others (Liddle & Diamond, 1991; Liddle et al., 1992). After the engagement phase, individual sessions with the teenager focus on his or her drug taking and other related problem behaviors. Intrapersonal and interpersonal aspects of drug taking and/or delinquent behaviors are discussed. The adolescent's relationships inside and outside the family are also assessed. Another segment of the session with Alonso follows, illustrating this relationship focus.

A: *When I was like 11, that's when everything got bad. Like in the same year, three close people died; I got kicked out of school, out of Central. I only went there for 1 year.*

T: *Why'd you get kicked out of school? What happened?*

A: *I don't know just, like, reckless behavior and stuff like, you know what I'm saying. Bad attitude, you know what I'm saying.*

T: *Did you go to school or was it that you didn't go?*

A: *Oh no, I used to go to school.*

T: *You went, but you'd just get in trouble.*

A: *Oh yeah, I used to have fights and stuff like that.*

T: *Right, right.*

A: *And they don't really allow that. So then my mom said, "Well, you got kicked out of school, you're getting kicked out of here." She sent me back with my dad.*

[later in session]

A: *But I always liked my dad, you know what I'm saying. Because, I mean, he got like 15 kids, and he always look out for me, you know what I'm saying. Well, he look out for everybody; the man got money. So whatever, I went back, and I didn't like my mom because I was 11, and she had already kicked me out one night. And I was a little kid, and I had to sleep on the roof of the building, you know what I'm saying. And it was cold.*

T: *And that's what you did, you slept up on the roof of the apartment building?*

A: *Yeah. But then I just, one day, 'cause I was sick of being there, I just ran away, bam, I never came back. I packed all my stuff, out of the door.*

T: *And where'd you go?*

A: *I was living on the street. I was living with my one of my dawgs* [slang for a teen's friends] *on the West side.*

T: *Mm hmm.*

A: *But that couldn't last, you know what I'm saying, you can only stay at someone's house for so long, you know. But he gave me some drugs, he showed me how to, you know, to hustle.*

T: *To serve* [to deal drugs], *right?*

A: *Yeah. And, I wasn't really doing it for a bad reason. Like, I was doing it because, you know what I'm saying, I needed to stay alive on the street. My mom, she didn't know any of this—didn't know about my serving.*

T: *So you're 12 now, and you're serving in the West side.*

A: *Yeah, this only lasted, like, 3 months, not even—2, 2½ months.*

T: *Mm hmm, and what happened?*

A: *Through all this time I'm talking to you, I'm doing drugs, every day.*

T: *What were you doing?*

A: *Cocaine, everything, you know what I'm saying?*

T: *So from 10 to 12—we're still at 12?*

A: *Ten to—we're still at 12.*

T: *Ten, eleven, twelve.*

A: *I'm doing drugs every day.*

T: *And you're doing cocaine every day. Okay.*

A: *You know what I'm saying, because I was living so messed up, and even on the streets, I'm gonna have to fight, run from cops, you know what I'm saying.*

T: *You were carrying?*

A: *I carried weapons.*

T: *Who gives a weapon to a 10-year-old boy?*

A: *I bought 'em.*

T: *And where does a 10-year-old boy buy a weapon?*

A: *On the West side, it ain't that hard.*

T: *Really.*

A: *I knew everybody. Yeah, I knew most of them, but even when I was a little kid I didn't look like I was a little kid, I looked a little older. When I was 11, they thought I was 13.*

T: *Okay, so you bought a gun.*

A: *Yeah, so I said, man, look man, I'm homeless, pssh.*

T: *And you were.*

A: *I'm sleeping with fresh clothes that I'm buying from selling drugs, a lot of money in my pocket, I'm sleeping on a bench.*

T: *Mm hmm.*

A: *In the middle of a park, you know, so I'm like, somebody might just come up, dig in my pockets. I say one thing, they blow my head off; I need my piece.*

Key Concept:

A drug-using lifestyle can be understood as an *indicator* of difficulties in meeting previous and current developmental challenges, a *predictor* of problems in meeting future developmental milestones, or a *creator* of problems in crucial developmental areas.

A drug-using lifestyle can be understood as an indicator of difficulties in meeting previous and current developmental challenges, a predictor of problems in meeting future developmental milestones, or a creator of problems in crucial developmental areas (Baumrind & Moselle, 1985; Shedler & Block, 1990; Dishion et al., 1995). That is, drug use may be a marker or reflector of problems in family functioning, but it may also create disharmony or exacerbate already conflicted family relationships. Thus, a therapist's attempt to focus on drug use assumes that drug involvement both reflects problems in functioning and development and is, itself, a current stimulus for other problems and negative relations.

Remarkable changes have occurred in how substance abuse has been conceptualized (Miller & Brown, 1997). Understanding drug use contextually means that diverse aspects of the drug user's environment are understood as contributing to the continuation of drug taking. Prompting change within and between several persons requires a foundation of interconnected therapeutic relationships or alliances. This clinical objective is decidedly more complex and ambitious than is required in standard individual treatment. However, the multidomain assessment and intervention requires a more comprehensive scope than the previous generation of treatments (Kazdin, 1994).

The most important therapeutic alliances in MDFT are those of the therapist–adolescent and therapist–parents. Process research indicates that when successful, the therapist–adolescent alliance proceeds through stages (therapy socialization, expression of concerns, agenda setting, and beginning problem solving) (Diamond et al., 1997).

An initial negative alliance with the adolescent can be reversed by certain therapist behaviors. For example, one study found early-stage therapeutic participation in drug-using African-American adolescent males could be enhanced when certain themes were discussed (the "journey from boyhood to manhood," social exclusion or marginalization, experiences in public spaces where young black men are thought to be more suspect and potentially dangerous, or "alienation" from mainstream societal beliefs and values) (Jackson-Gilfort & Liddle, in press). Generic treatment principles are tailored to individual cases.

It is a challenge to achieve a workable focus with unmotivated adolescents. An effective means of achieving this focus is through the teen's and parent's emotional life (Liddle, 1994a). The therapist elicits the emotions related to important life circumstances and events. Feelings about parents, siblings, peers, and oneself; emotions about family life; or disappointment, hurt, and anger are important markers of, as well as pathways into, the adolescent's world (Diamond & Liddle, 1999). When emotions such as these are accessed, working with them can be instrumental in facilitating motivation for self-focus and for resolving in-session impasses between family members (G. S. Diamond & Liddle, 1996). Another portion of a session involving the therapist and Alonso illustrates a focus on emotional expression.

A: *My mom knew I was doing good. And we started building up a little bit of a relationship, but [when] you grow up like that, not liking your mom, your mom not liking you—you just can't expect to make a connection after all that. I still had that in my head that she locked me up for all this, you know. If she woulda been doing her job, maybe I woulda learned.*
T: *So she kind of acted like she expected there to be instant love.*
A: *Yeah.*
T: *And you're saying it can't be instant.*
A: *Yeah.*
T: *Okay, you were like willing to try, but it just wasn't gonna happen over night, right? Is that what you're saying?*
A: *Yeah. Exactly.*

These small steps toward expressing emotion are not insignificant. Focusing on these feelings, and the past and present issues from which they emanate, is a standard way in which therapy becomes defined for the teenager and initial treatment content and focus are established (Diamond & Liddle, 1999).

Key Concept:

Knowing adolescents' conceptions of the roles of drug use, their peer network, and other aspects of their lives creates a window into their world, a pathway to change.

With many adolescents, articulation, whatever one may think of its content, is difficult. It seems to be an activity to which they are unaccustomed or in which they sometimes appear to have little skill. Thus, using their discussion about their drug use is a helpful first step. Knowing teenagers' conceptions of the role of drug use, their peer network, and other aspects of their lives provides a window into their world.

The last portion of a session with Alonso provides a look through that window.

A: *Everything's all messed up now, you know what I'm saying?*
T: *What was all messed up?*
A: *My whole life! All my dawgs were going to jail, my dawg got shot up. He died. And, you know, I'm still in this stage like, nobody cared about me, I don't care about nobody.*

Themes characterize and encapsulate the emotionally meaningful past and current events, experiences, or circumstances of teenagers. Frequently, these themes relate to aspects of the identity and self-definition of the adolescent's or parents' development (Dix, 1991; Oyserman & Markus, 1990) and to relationship-oriented themes as well (Diamond & Liddle, 1999; Liddle, 1994a).

Although teenagers can eventually accept a treatment goal of drug use reduction or elimination, this is rarely their initial position. Requiring an adolescent to admit to a drug abuse problem may preclude many teenagers from receiving treatment. Whereas traditional drug abuse treatments sometimes focus exclusively and directly on substance use and abuse, many contemporary treatments emerging from the psychotherapy field have developed strategies that focus on changing substance use indirectly (Miller & Brown, 1997). Although it is preferable to influence drug taking directly by having access to and targeting the immediate behaviors that continue and support substance use, such access and direct intervention are not always possible. In fact, with moderate and more severe juvenile justice-involved adolescent drug abusers, direct access or willingness on the adolescent's part is unavailable most of the time.

The first stage of treatment is particularly important in the adolescent subsystem module (Liddle & Diamond, 1991). Offering a unique, supportive, but challenging therapeutic relationship in which the adolescent has, alternately, an advocate, a supporter, a representative, and a translator vis-à-vis other family members and extrafamilial others is a viable way to launch drug treatment with treatment-referred or treatment-mandated youth (Liddle et al., 1992).

The extent to which teenagers allow a focus on drug-taking behavior in treatment varies. A critical method of achieving a drug use and abuse focus in treatment uses drug screen (urine testing) results. Urine screening can be done weekly at the outset of treatment (or throughout treatment, in some cases). With the adolescent's agreement, and as part of the treatment program's guidelines, these results are shared with parents. This procedure is defined as a program requirement and is explained to the adolescent and parents at the outset of treatment. (See Clinical Guidelines: Dealing With Drugs in MDFT on page 70 for the protocol on how to use urinalysis [UA] results in a session.) Sharing drug screen results with other family members in family therapy was first done in the Addicts and Families Project (Stanton & Todd, 1982).

Although clinical targets for teenagers have much in common across cases (e.g., these targets might be intrapersonal or interpersonal processes and are organized into domains that pertain to the self, parents, the family, and extrafamilial persons), the sequence of attending to them and the combinations in which they might be addressed vary. Many of today's substance abuse interventions do not focus exclusively or even primarily on substance use. They address, as do MDFT and other multicomponent, comprehensive, ecologically focused, and developmentally based models, a "complex array of adjustment problems" (Miller & Brown, 1997, p. 1272) known to be related to the creation and continuation of drug taking and related difficulties. Current treatment development focuses on elaborating on different ways to address drug taking. Sometimes, the focus is directly on drug use and working with the drug-taking behaviors of the youth simultaneously with work in other domains (e.g., family relationships). When this focus is available for use with the teenager, it should be used. In cases in which access to drug taking and discussion of drug use are not present initially and the therapist cannot gain access to them, the focus on drug use is achieved in a more indirect manner.

Adolescent Engagement Interventions

Key Concept:

Adolescent engagement interventions build alliances with adolescents and are crucial to engaging an adolescent in treatment.

The majority of substance-abusing adolescents will come to therapy only because their parents or the juvenile justice system ordered them to treatment. Adolescent engagement interventions are techniques for building alliances with drug-using adolescents (Liddle & Diamond, 1991; Liddle, 1993, 1995). These interventions are rooted in empirical and clinical knowledge about the difficulty of engaging adolescents in treatment and the adolescent development literature that emphasizes the adolescent's disconnection from prosocial institutions (including family and school), which constitutes a major risk factor for drug use and associated problem behavior.

Because active participation by a teenager in the therapeutic process increases his or her chances for success, it is vital to help the adolescent formulate a personal therapeutic agenda. Without it, engagement will be compromised. The adolescent must be convinced that therapy can be personally worthwhile. The therapist must show the teenager, through both words and actions, that therapy will be more than just helping the parents become more powerful and controlling. Engagement and alliance-building strategies are continued throughout the therapy. These strategies have been developed in the context of previous research (G.M. Diamond & Liddle, 1996) and include the following:

1. **Developing a collaborative mindset.** The therapist presents therapy as a collaborative process as opposed to a coercive or authoritarian process.

2. **Forming goals.** The therapist attempts to help the adolescent define therapy goals that are meaningful to and worthwhile for the adolescent and delineates therapy tasks related to that goal.

3. **Generating hope (via contingency and control beliefs).** The therapist and teenager discuss the degree to which the adolescent believes that his or her life can change for the better. This includes having the therapist make statements that combat the adolescent's belief that he or she cannot effect positive change in his or her life.

4. **Generating hope (by the therapist presenting himself or herself as an ally).** The therapist states that he or she is willing to work with the adolescent and, in this relationship, to facilitate the adolescent's expression of his or her beliefs and opinions. The therapist presents himself or herself as an ally who will support the teen's quest for positive change.

Many substance-abusing adolescents feel they have little control of their emotions, thoughts, behaviors, and daily life. Although they may not be able to precisely articulate how they experience the world, many adolescents have an unmistakable sense that something in their lives is desperately wrong. Several interventions are used to alter this sense. First, MDFT has high expectations for the adolescent and attempts to increase the teen's own self-expectations by providing alternatives—holding up certain desirable behaviors and saying, "This is what you can do, this is what you can be, this is how you can get along in the world, and this is how you can interact with your parents." The materials used to sketch this portrait of higher expectations for each family (e.g., attributions, emotions, the past) may be different, but the message is always the same: "You can do better, and I'm going to help you do better."

In addition, MDFT presents high expectations of the parents to the adolescents. Teenagers are told about the goal of helping their parents be better parents—to be more fair, to listen to and acknowledge them, and to be more responsive. By talking to adolescents about their parents' parenting, the therapist makes the teenagers aware that responsibility for change does not lie solely with them. This serves to counter some of their pessimism about the possibilities for change. It can be a difficult balance to maintain, but adolescents should feel some degree of responsibility to help alter their parents' behavior—but not too much responsibility. The therapist creates a partnership with teenagers that helps them deal with their parents and how their parents treat them. Adolescents appreciate having, and often need, a spokesperson, even one who is not always completely on their side. They are accustomed to a world that does not respect them, expects them to be unreasonable, and in general incorrectly understands adolescence as a time of necessary storm and stress (Offer, Ostrov & Howard, 1981).

In addition to increasing their expectations, MDFT literally and figuratively helps adolescents find a different language to use and thus a different way of being in the world. In one case, a therapist tried to help a boy communicate his unhappiness and frustration through words rather than through violence and self-destructive actions.

The desired language is one in which the adolescents can, to the best of their ability, explain their subjective experiences, world views, hopes, dreams, complaints, and disappointments. Working with the parents is just as intense, so that they will be receptive to their adolescent's new language. The following is an example of the type of communication that therapists encourage:

> **Therapist (T):** *So you felt as if you didn't know what was happening with your mom, Willis? Were you really scared?*
> **Willis (W):** *I was little—6 or 7 years old!*
> **T:** *You thought maybe she was dead or something?*
> **W:** *Yeah! Every night she used to go out.*
> **T:** *Every night you used to wonder if she'd come back.*
> **W:** *Yeah! But she don't care at all.*
> **Mom (M):** *Why should you say I don't care?*
> **W:** *You don't care!*
> **M:** *You know I care.*

W: *You don't care. All your feelings is against me. You don't care what my feelings is against you. 'Cause you never will let me talk.*

M: *'Cause first of all, I never in my life let anybody worry about me. I didn't even let my mother worry about me. 'Cause I always felt I could take care of myself.*

W: *But you don't feel like I came from you!*

T: *Now, keep going, keep going! It's important that she hear what you're saying. Come on, Willis—don't bail out. You said you came from her—*[to mom] *Do you hear what he was saying? What was he saying a minute ago?*

M: *He was saying that he came from me, and he wants to worry about me.*

W: *'Cause you're the only one who loves me!* [pauses] *Always seems like nobody else cares about me.*

Key Concept:

MDFT literally and figuratively helps an adolescent develop a different language—a new way of conceiving and expressing his experience in the world.

Many teenagers have difficulty finding words to express their concerns and share their inner experience. In the following description of a family session, the adolescent chooses to act out his efforts to get his life back on track.

During a session in which the family is discussing Willis' tendency toward property destruction, he seems to tire of the topic and proclaims, "Look, I'm trying to get my life straight! I want to go to school, get a job, buy a car." He then goes on to say that he wants to go down the "good road" and that he is trying his best. He even gets out of his chair to demonstrate his efforts to walk down the good road and slipping onto the bad road. The therapist senses that Willis is trying to communicate something very important to his mother and her partner. So the therapist asks them to all talk together about concrete things that can help Willis "walk toward the good side." The therapist also asks Willis to tell his mom and his mom's partner about the bad side. Willis' mom and her partner ask him about his friends—who they are and what they do. They talk about whether he can say no when his friends try to convince him to smoke marijuana. The therapist congratulates him for his good intentions and responsible talk during the session. Willis goes on to talk more about how his friends influence him to smoke marijuana. He even impersonates their voices and uses their words to demonstrate what happens out on the street and shares some important beliefs of his own about smoking marijuana.

Developmental progress occurs at the cutting edge of a teen's current stage of functioning and understanding (Baumrind & Moselle, 1985). To acquire higher levels of social reasoning and interaction, an adolescent must overtax his or her previous schemes of thought and action. Growth occurs by mastering the disequilibrium that constitutes the impetus for development. Drug users tend to "turn on and tune out" and have no context that facilitates or guides their entry into the necessary fray of life. Treatment, which first occurs through the mechanism of alliance building between a therapist and adolescent, serves as a context to reinstate a core developmental challenge.

This engagement of the adolescent and the definition of an agenda for him or her in therapy is a primary goal in MDFT. It requires the therapist to work with both parental and adolescent systems simultaneously, even though the activities in each may seem contradictory. The therapist can increase the probability of the teenager's success by assuming a posture of respect and support for the adolescent's personal experience, both inside and outside the family.

This therapeutic posture is not one of "child-saving" but rather one of acknowledging that the adolescent has his or her own story that can be "heard" in this therapy. This is especially important because drug-using teenagers have been found to experience a lack of personal control over their own lives. The teens also feel a profound meaninglessness or lack of direction (Newcomb & Harlow, 1986). MDFT addresses these influential organizing themes by, among other interventions, working alone with the adolescent for significant periods at all stages of therapy.

Case Example: There Is Something in This for You

The following case excerpts, which come from the end of session one and the beginning of session two, illustrate how a therapist might develop and work with the content theme "there is something in this (therapy) for you." Sam, a 16-year-old adolescent boy, is the youngest of four children. At the time he entered therapy, Sam regularly used alcohol and marijuana. He had had a history of severe school and behavior problems since the second grade. Sam had difficulty expressing himself verbally and instead often resorted to violence. This seemed to be his predominant way of dealing with his hurt, anger, and disappointments. By the time Sam came to the Adolescents and Families Project, almost everyone (i.e., schools, other therapists, probation officers, his parents) had given up on him. They had judged Sam to be too out of control, too violent, too incompetent, and too unintelligent to be a good therapy candidate. One goal of Sam's therapy was to support his feelings while helping him change how he expressed those feelings. An effort was made to make his language and behavior more civilized and appropriate. Although his parents had separated a year earlier, they both agreed to attend therapy.

The therapist spent most of the initial session talking with Sam's parents about their family history and current problems. During this discussion, Sam was somewhat indifferent and periodically belligerent. He was seen alone for the last 10 minutes of the session.

Therapist (T): *So what do you think of this?*
Sam (S): *It's cool.*
T: *You've never been in therapy like this, have you?*
S: *No, not like this.*
T: *Do you feel nervous, do you feel…*

S: *No.* [matter of factly] *It's just another counseling.*
T: *I don't think it's going to be another counseling. That's not the way I work. I think we could do a lot here. But, I guess one thing I want to know is whether you're going to work with me. You know what I mean by that?* [Sam nods]
T: *You see, I'm really interested in who you are in this family, and who you want to be, as your own person, Sam. But, I'm going to need your help. Do you think you can help me with it?*
S: *I can try.*

The therapist begins to set the foundation for engaging Sam in therapy. The therapist establishes his expertise and confidence, tests whether Sam is willing to accept optimism, and acknowledges that he has a point of view that needs to be expressed. Because the family, school officials, police, and juvenile justice system officials generally see adolescents like Sam as antisocial, addicted, or disturbed, asking for a teenager's help can counter the biased conceptions that the adolescent has about adults in authority. The adolescents, parents, extrafamilial sources of influence, and the therapist are all equally central to this approach.

T: *Well, you told me last week, when the big fight happened with your father, that you don't like dealing with your anger that way.*
S: *I don't, man, but that doesn't mean any of you are gonna make me change. Maybe I'm wrong, I'm not saying I'm not.*
T: *Would you be interested in learning how to deal with things better?*
S: [pauses] *Yeah. I would.*
T: *That's something we could do here. You know, you didn't look so happy when you were hitting your dad.* [Sam had kicked and hit his father in the family assessment the previous week.] *And you told me you hate when you get mad at him. I didn't think you looked too happy. Tonight, I felt that there were times when you weren't happy. You didn't like what they were saying. Maybe you don't feel they understood you enough. Maybe you feel as if you get between your parents. You know, it's a hard situation, your parents' being split up. They're still working things out. It's going to influence you. I know that's rough. So, I want to help you work through some of that in a way that would work for you. But I'm gonna need your help.*

Key Concept:

Crafting themes requires recognizing, highlighting, and carrying forward to other sessions indications that the adolescent would like something to change.

MDFT looks for opportunities to develop positive themes and goals with the adolescent and parents. These must be recognized, highlighted, and carried forward in sessions and from one interview to the next.

The therapist must carry forward these themes, or as Minuchin & Fishman (1981) call them "partial truths," and lend them back to the adolescent or parent. In Sam's case, by keying in on Sam's statement about how he would like to find a better way to handle his anger, the therapist demonstrated to Sam that his words are remembered and taken seriously. His statement is used to remotivate him during difficult times or in the early stages of work to help illustrate therapy's possibilities.

Sam presented as a poor therapy candidate. Most people believed that Sam's feelings should be avoided. He was cast as a youngster whose predominant feeling (and the one that he was most adept at communicating) was anger. MDFT work was begun with Sam with the assumption that Sam was more complex. MDFT distinguishes the therapist as a person who can understand adolescents; confirm their right to have and present their perspective;[1] and sometimes, at least, take their side.

T: *What does that all sound like? Do you want to give it a try?*
S: [indifferently] *Yeah.*
T: *Would you like to see things change?*
S: *Sure.*
T: *What kind of things? What would you say?*
S: *I don't know, just how I get along with everybody.*
T: *Do you feel like you get along with your mom now?*
S: *Yeah. Better than I used to.*
T: *How about your dad?*
S: *All right.*
T: *It sounds as if he would like to be closer to you. Is that something you share?*
S: *I don't know.*
T: *You don't know? Hmm. Well, it's perfect that you say that, because that's exactly the kind of thing I'm gonna ask you not to do. I'm going to ask you to say, "Yeah, this is what I hate or this isn't what I want." Even when it's difficult. But sometimes they're hard to say. You're afraid you're gonna hurt somebody, or get angry at them, or you might not get what you want. But I want to help you be more straight with them.*

This dialog served simultaneously as an intervention and assessment. The therapist attempted to obtain answers to the following questions: Is the adolescent willing to respond to the framework that the therapist is offering? Can the teenager identify with these concerns and begin to articulate his own story? In which direction is the adolescent leaning about the possibility of a therapeutic relationship at this early point?

Whereas some adolescents will quickly respond to the therapist's offer of empathy and understanding, others remain not only distrustful but hostile. The term "resistance" takes on new perspectives in light of such factors.

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[1] *Understand* and *confirm* perhaps do not carry enough of the connotation of how these realities are both understood or confirmed *and* shaped, simultaneously. At this stage of therapy, however, given the developing therapeutic alliance between therapist and teenager, it is probably more accurate to say that the aim is for a more "pure" understanding and confirmation of the reality of the adolescent's life as he or she experiences it.

Another theme here concerns the definition of a relationship that will serve as a context to develop new relational and conceptual skills. In essence, the therapist told Sam that it is important for him to communicate more effectively with the world and, in a sense, with himself about his reactions and experience.

In the previous example, Sam's tentative responses are a cue not to push too much. By meeting Sam's tempo, but sometimes extending the apparent limits, the therapist and Sam together coestablish a session's pace.

Establishing a link to the first interview, the therapist began the second session by meeting with Sam alone. New information, as it emerges, must be factored into therapy.[2] Before this session, Sam had received the news that his probation officer wanted to send him to a boys camp for a year because he hit a teacher at juvenile hall. This crisis was used to heighten the importance of Sam's participation in treatment. The segment begins with Sam's explaining that, if he is sent to the camp, he will run away.

S: *I mean, I don't care about doing time.*
T: *What do you mean, you don't care about doing time?*
S: *Oh, I care about doing time, but I don't want to be that far away from my parents where I can't.*
T: *Sam! I don't get it. I appreciate that you want to be around them, but how does it happen that you get in such tangles with them?*
S: *My dad just starts arguing and I snap. I know they're not going to get back together, but it still hurts me when they start arguing, even if it's petty.*
T: *I want to ask something of you tonight, and it's going to be really hard, because I think you're in a lot of pain in this family, right?*
S: *Kind of.*
T: *What?*
S: *Yeah. Maybe.*
T: *You admitted it to me the first time we met!*
S: *I know.*
T: *Why don't you like to admit it?*
S: *I don't know, man.* [starts to cry] *Everything is just messed up.*
T: *So, you try to be tough so nobody knows you're hurting? Does it feel safer that way?*
S: *Yeah, usually, then people don't ask me what I'm feeling.*
T: *People don't ask you questions because they just think you're wild and out of control?*
S: *What?*
T: *Talk with your parents about how upset you are. Because I think they would have a different take on you if you could be straight with them.*

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[2] One of the most difficult challenges for any therapist is providing therapy with consistent themes (which, of course, develop and evolve over the course of therapy) while incorporating new content into these themes. This new content often serves as a major factor in the themes' transformation.

Sam began an important process. He is starting to share what might be called the story of his life. This example illustrates how the affective realm is used, in part, to engage the adolescent in the therapeutic process of examining his or her life and generating alternatives. (Work in the emotional domain is done with the parents as well; see The Parents and Other Family Members Subsystem Module on page 105.)

Key Concept:

Catharsis or emotional expression, per se, is not a therapeutic goal. However, focusing and facilitating a teen's or parent's emotional expression may be necessary as a pathway to, and perhaps as a mediator of, individual change.

Again, MDFT targets multiple realms of life for assessment and intervention. The affective realm is but one of several targets of the therapy. Not all teenagers are willing or able to talk about their emotional disappointments, nor is it necessary for every adolescent to do so. Catharsis or emotional expression, per se, is not a goal of the therapy. However, conversations about one's feelings are one important aspect of multidimensional work. They are a pathway to create individual change, solidify engagement, establish and maintain alliances, and help family members establish new and healthy ways of being with each other.

Key Concept:

An important goal with all teens is to help them acquire a new language, a means of making sense of their lives and behavior, as well as a means of communicating this meaning and interpretation to others.

In this session, the therapist facilitated Sam's description by empathically appealing to the affective side of the story. Affective content became a therapeutic foundation with Sam and his family. This addresses the question: "Can I create a setting in which (partly as a result of his interactions with me) Sam can relate to his parents?"[3] At the outset of such hoped-for transactions, as was the case here, it is sometimes sufficient to simply have adolescents sort out, in conversation with the therapist, their many and frequently overwhelming feelings. Ultimately, however, an important goal with this teenager, and with many others, was the development of a *new language*. This term is used to describe a new way for adolescents to relate their experience to the world and replace defiant acts and self-administered anesthesia (e.g., alcohol and drugs) with more functional thoughts about themselves and others, feelings, and behavior. The goal is to help teens find a new way of being in the world. Treatment develops new options and interests for the teen.

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[3] Although *modeling* certainly is a factor in a change process of this nature, the MDFT conception of change centers more on the work that occurs in the therapeutic relationship between therapist and adolescent and on the changes that are practiced outside the therapy session than on a modeling theory per se.

Clinical Guidelines: Dealing With Drugs in MDFT

Many family therapy models have ignored the topic of drugs (except Stanton and Todd, 1982; Kaufman, 1985; Waldron, 1997; and Fals-Stewart and, in the alcoholism area, O'Farrell and Steinglass and colleagues) or have been less than clear about how to address drug use within a family therapy-oriented treatment. Family therapists are not alone in this regard. Miller and Brown (1997) describe a similar situation in the fields of psychotherapy and alcohol and drug abuse.

Early in the development of family therapy, drug treatment was left to the experts in the alcohol and drug field, whereas most of the drug experts kept out of mainstream family therapy and psychotherapy. The classical family therapy philosophy warned against overfocusing on the symptom (whichever symptom happened to be present). Some perspectives in family therapy, most notably Haley's (1976) problem-solving therapy, did not ignore the symptom and used symptomatic behavior as a motivator to focus on and leverage change in family and other relationships. Even in Haley's approach, classic family therapy thinking remained—the key to changing individual symptomatology was in changing family interaction. These early periods of family therapy rejected "disorder-based" thinking. Although this has changed considerably (see Pinsof & Wynne, 2000), it is easy to see how this preoccupation affected family therapy's movement into clinical specialties such as drug abuse.

MDFT, Drug Abuse, and Standard Family Therapy Practice

There are several areas of agreement between MDFT and standard family therapy practice:

- It is important to look at drug use and abuse in the context of other symptoms.
- The therapist should try to link drug use and abuse to family relationships and to individual functioning and contextual circumstances.
- It is important to overtly define drug use as a form of communication about the adolescent's circumstances.

The following are two areas of disagreement:

- In early-stage family therapy terms, dysfunctional children were "saving" the family by holding together parents who might otherwise separate or divorce. MDFT holds no such beliefs about why symptomatic behavior exists. Although a teen's drug taking may indeed be related to problems in the family, some of which may be longstanding, it is also possible that the antisocial behavior of the teenager, including drug abuse, may be more related to peer, interpersonal, or other environmental factors than family relationships. Drug use and drug taking are seen as problems of development.

- MDFT does not assume that changes in family functioning (changes in parenting practices or in parent–adolescent relationships) are sufficient to alter drug-using behavior in all cases. (See Schmidt, Liddle & Dakof, 1996, on the relationship of parental change to adolescent changes in drug use and behavior problems; Palmer & Liddle, 1994, on the association between parent–adolescent relationship changes and adolescent school performance [grades]; and G.S. Diamond & Liddle, 1996 and 1999, on resolution and nonresolution models of in-session parent–adolescent relationship conflict.)

MDFT, Drug Abuse, and a Chemical Dependency Model

There are two areas of agreement between MDFT and a chemical dependency model:

- Drug abuse has serious health and social/emotional developmental consequences.

- The specifics of drug taking must be focused on directly (e.g., not all symptoms are the same, not all can be treated by the same methods). Methods such as conducting a behavioral analysis of the circumstances of drug use (e.g., people, places, things), determining the course and development of drug use, and identifying ways in which it is presently maintained are core aspects of any responsible treatment of adolescent drug abuse.

The following are some areas of disagreement between MDFT and a chemical dependency model:

- In MDFT, creating a framework for dealing with drugs and one's life in an overt manner is most important and useful. This framework promotes cooperation and creates the kind of context that enhances health and development rather than patienthood.

- Although it is true that parents can enable the drug use of their teen, in MDFT it is assumed that changes in the parents' behavior and family environment that are organized by parents can have an influence on the drug use of the teenager.

- In MDFT, teaching clients that they use drugs because they have a disease may not enable them to examine the multiple aspects of life that can provide concrete alternatives to a lifestyle of drug and antisocial involvement. (See Alexander's "adaptive model" of drug use and abuse [Alexander & Hadaway, 1982] as well as Peele's model [1986].)

- Generally, the greater the number of risk factors present, the more directly the therapist focuses on drug taking and drug abuse early in treatment. The following risk factors are used as guides for tailoring and calibrating MDFT interventions.

- Early-onset drug use
- Frequent use of hard drugs with marijuana and alcohol
- Regular and patterned drug use (versus binge or episodic use)
- Strong bonds with drug-using peers
- Drug use by parents, another significant adult, or sibling
- Neighborhood or community risk influences
- Significant disconnection from school and family.

How To Deal With Drug Use and Abuse

The following are points to keep in mind when discussing drug use in the context of MDFT:

1. Family or parent involvement is critical. But a change in parenting or in parent–adolescent interaction is not necessarily sufficient for a change in adolescent drug use, especially if several risk factors are present.

2. The more patterned the use, the more important interventions to domains outside the family become. These interventions are intense, comprehensive, and able to directly influence the drug-using behaviors. The circumstances that are maintaining the drug-using behaviors are not all interpersonal, familial, or related to the past or current quality of parenting.

3. The therapist uses individual sessions with parents in specific ways (e.g., to buy time, to teach them about what aspects of the teenager's behavior they should attempt to influence and what they should not deal with directly, to teach them how to be more than a detective, to teach them how to talk to their adolescent about many topics, including drug behaviors).

4. MDFT uses individual sessions with the teenager in another important way: framing the therapy, what it is about, and what it might do (e.g., get them off my back, get probation off my back, do an inventory of my life, work on particular behavior, talk over my life with a mentor or friend).

5. The parents' stand against drug use, as well as their clear communication of this stand, is a strongly predictive protective factor (see Hawkins, Catalano & Miller, 1992). An important part of the therapist's function is to help clarify, refine (if necessary), and articulate the parents' stand against drug use. Some resources to assist the therapist in this endeavor that can easily be adapted with the MDFT parenting module are Parents: The Anti-Drug (www.theantidrug.com) and The Parent's Role, and Tips (www.drugfreeamerica.org/).

The following points illustrate how drug use and drug taking are conceptualized and discussed in MDFT. This type of strategy is important because it is challenging to facilitate a successful drug abuse focus in treatment with teens.

1. Drug use is indicative of a health-compromising lifestyle. This focus places less emphasis on the morality of drug use and abuse and more emphasis on the context or lifestyle. Parents are encouraged and helped to directly articulate to their teen why drug use is a problem.

2. Drug use is a choice, something that one willfully does for definable reasons. The frame for the teenager is "sometimes choices on one occasion happen over and over again; they become habits." Succeeding in this realm means that workable and useful frames are created.

3. Parents are more important in early adolescence than later when peer influence assumes greater strength. Their interventions need to take peer influences into account as directly as possible.

4. Generally, when teens are using drugs a great deal, there are consequences that are upsetting to them such as dating problems, work problems, school failure, family disaffiliation, and/or extreme negative feelings about themselves.

5. Some drug use is normal. In some cases, drug use can be part of a natural experimentation process coupled with a teen's propensity toward risk taking (see Newcomb and Bentler, 1989). But adolescent drug abuse is a sign of developmental difficulty and dysfunction and indicates the need for intervention.

Overall, MDFT seeks to develop drug use as a physical and mental health issue and a lifestyle issue like smoking, driving while under the influence, not using seat belts, dropping out of school, poor nutrition, unsafe sexual practices, and delinquent and antisocial activities. Asking about, and discussing in detail, smoking, use of condoms, use of seat belts, drinking or drug use while driving, or drug use in situations that compromise safety and well-being can develop content themes.

The goal is for the adolescents to talk with the therapist about their lives, including their psychological and physical health and their conception of health and lifestyle issues, their neighborhood (e.g., safety, availability of drugs), and other social influences such as parents and peers. Health and the facilitation of development are promoted, and factors that detour teens from mainstream connections and possibilities are discouraged.

In-Session Interventions Pertaining to Drug Use

The therapist does not reveal to parents an adolescent's discussions about drug use in individual sessions, but he or she does talk with them about what drug use represents. It is important to establish confidentiality ("Is it okay that I talk with your son about his drug use, although we will not always talk about it here with you present?"). The adolescent is to discuss with his or her parents not only drug using per se but the context in which drug use and other problem behaviors have existed. The previously outlined technique of establishing a separate therapeutic relationship with the teenager and the parent is used to orchestrate discussion of sensitive issues about drug taking and delinquent and antisocial acts.

The symptom frame is used sparingly and not this way: "You are doing this because you are afraid to grow up" or "You are keeping your parents together or keeping them involved with you and not with each other." Even though drug use may be connected to these "other things" and unhappy relationships with parents, the treatment has to focus on drug use itself (the circumstances of use, patterns of use, social environment of use). Therefore, it is important to talk about it directly.

The way MDFT programs talk about drugs is different from the way other programs talk about drugs. Research on adolescent rolelessness (see Nightingale & Wolverton, 1993; the Carnegie Council on Adolescent Development Report, 1989; and Takanishi, 1993) in our society reveals that many teenagers do not have sufficient contact with or opportunity for relationships with adults (e.g., socialization and natural mentoring). Adolescent behavior and problems must be understood from this perspective as well. Similarly, the introduction of cultural perspectives is not excluded or incompatible with this perspective (Jackson-Gilfort, Liddle & Dakof, 1997).

The adolescent is not only drawn to the peer subculture but is actually pushed toward it by adults who are afraid, repulsed, hurt, and angered by the young person's behaviors and the consequences of that behavior (Steinberg, 1991). This is what therapy must undo.

Some issues to explore are what drug use means to the adolescent and what his or her philosophy of use is. The therapist attempts to obtain details about the adolescent's life as it pertains to using—not only details about how much and what kinds, but the real details—by asking questions such as: Who do you do it with? What is your relationship to them? What is the social setting when you use? What happens that is fun or pleasurable? The therapist looks for exceptions to the rule—that is, if the teen feels good while doing drugs, are there any aspects that are not fun, such as the danger involved? It is important to emphasize the social aspects of drugs such as the comradeship, socializing, sexual freedom, and release of social inhibitions.

Key Concept:

Guided by detailed description of an adolescent's lifestyle, the therapist becomes an expert on the adolescent's world.

No level of detail is too small. The therapist tries to feed into some of the natural egocentrism of the teenager (the telling of one's exploits). The therapist should not be impressed with, shocked by, or in awe of what the teen does. He or she should hear the details in a way that works to interpret and reframe them as the dialog continues. This process might be facilitated by using what is known about the peer worlds that adolescents inhabit such as the worlds of "jocks," "geeks," "brains," and "gang bangers." The therapist should get the teenager to be a tour guide to these different worlds and in particular to the group with which he or she is most identified.

All of this tries to get at the world that is walled off from most adults. (See Multimedia Interventions on page 99.) Adolescents are not cooperative with adults about these details, which are hidden for good reason—the consequences are or can be grave.

The therapist works alone with the teenager to get a ground-level view of the adolescent's everyday life. It is as if the therapist researched the daily comings and goings of teenagers by having them carry beepers so that they could check in with the researcher and report their activities frequently. The method of using some version of daily or near-daily diary cards (Linehan, 1993) to track drug use, circumstances of using, and feelings and thoughts while using has been tried.

Open discussion about drugs that is not punitive, coercive, or moralistic can be a startling new experience for youth. Enlisting teenagers in an outpatient therapy, even with the sanction of the court, requires great skill. In addressing these challenges, a therapist's capacity to define treatment in personally meaningful and motivating ways is critical to successful engagement. Content and process aspects of this framing process are evident in what we call the NYPD Blue intervention: "You are at a turning point in your life. What you do here can help or hurt you. I can help your situation" (with parents, school, probation). This is one of the standard stances taken by interrogating detectives with a suspect who finds himself in a tight spot. Here, the suspect is being detained because he is under suspicion for committing a crime, and the detective, in the interrogation, offers a deal if the suspect will admit to the crime or provide information about another suspect.

This general strategy has been a common one in the behavioral therapies for some time: "I want to know whether you are interested in joining with me against the drugs, the streets, and the other things. Are you interested in learning how to take a stand against drugs and the forces that pull you to them?" In addition to its recent adaptation in family therapy, this method has been used as part of the chemical dependency model of addiction and intervention: "It is something that you cannot help; you do it, but it is out of your control." In this strategy, drug use and what comes with it (school failure, poor social skills, affiliation with losers) are unfortunate because they can get the user in trouble and prevent him or her from experiencing what life has to offer. It also goes with the standard statement: "Your current way of being is not working out very well. It is not helping you tell your story, get what you want, define who you are, or tell whom you're becoming." The following conversation completes this framing technique:

> **Therapist (T):** *You are using now, right?*
> **Adolescent (A):** *Yes.*
> **T:** *Can you stop doing it? Or would you like to have some help in stopping it? I would like to help you take a stand against all of this trouble that's happening in your life.*

Another frame has to do with defining treatment in a different way, such as:

> T: *I would like to see whether you would be interested in using this time to take a look at some areas of your life. To check in and do an inventory (what's going well, what's not), and ask yourself, "Where am I going?"—that kind of thing.*

Sometimes, the adolescent's agenda in relation to his or her parents can be used ("I can help you deal with your parents. They are very much on your back these days.")

In situations in which the youth says that he or she is not using, drug tests come into play. Urinalysis provides a basis to urge the teenager into discussion. A UA focuses so directly on the drug use and provides such corroboration of using behavior that it actually lets the therapist get past focusing on the drugs per se.

UAs have many other uses in ongoing treatment. If they indicate drugs are not present, they show the parents and other influential people or systems that change (in this realm at least) is occurring. This buys time, relieves pressure, and helps everyone develop a more cooperative, positive spirit about the teenager.

Several steps are involved in using drug screen results in treatment.

1. The therapist needs to establish that the topic can be discussed. This is not a small accomplishment. Even if the youth is dishonest and deceitful, the premise is that a frank discussion of use is better than continued secrecy and covertness. Furthermore, this accomplishment (making drug use something that is discussed openly) could be an important step toward change. Of course, when this discussion continues without change occurring, it may indicate that things will not progress beyond this first stage (even though this stage changed the context of the teen's use).

2. The therapist works directly on modifying some aspects of the circumstances of using—any modification is better than none at all.

3. The therapist works to get the teen to "observe" and comment on his or her own use or lifestyle, particularly the social circumstances and psychological, intrapersonal aspects such as feelings, mood states, thoughts, and behaviors.

4. The therapist works slowly, being careful not to turn the discussion into a one-sided attack on one aspect of the teenager's life.

5. Change in drug use, or in feelings or thoughts about drug use, can be presented to the parents as evidence.

6. From this position, the "storyboard" may look quite familiar, as new conversations with the parent are organized through individual work with the teen. The therapist moves back and forth between working this content into sessions with the adolescent and with the parent.

Adolescents are told that their use of drugs makes them ineffective at expressing their legitimate concerns and complaints, although each teenager has some valid reasons for his or her behavior and unhappiness. These problem behaviors are related to adolescents' inability to competently explain their thoughts and feelings, such as identity struggles and past hurts, to the adult world of parents and teachers. The therapist works with adolescents to convince them that therapy can be a forum where such communication improves.

There are times when adolescents are a danger to themselves or others. In these cases, a short hospitalization or placement (such as in crisis stabilization units and short-term halfway houses or shelters) may help establish a drug-free state and/or a needed timeout from the teenagers' families (and the families from them). In some of these short-term stabilization interventions, however, family sessions can be continued while the teenager is in residential placement.

Practical Guidelines for the Use of Urinalysis in MDFT

The MDFT therapist deals directly with the adolescent's drug use in therapy and monitors this use through weekly UAs. The UA used in the Cannabis Youth Treatment study screened for cocaine, amphetamines, opioids, and tetrahydrocannabinol use and included a temperature strip to verify unadulterated samples. The results of the urine screens are shared openly with both the adolescent and the family; the understanding that drug use will not be kept a secret is established from the beginning of therapy. The results of drug screens are not, however, reported routinely to juvenile justice officials. Sharing such information with a probation officer, for example, is at the discretion of the therapist and with particular goals in mind.

Clinical charts showing the presence of drugs offer concrete proof of their actions to teens who may be in strong denial (marijuana will stay in the adolescent's system for up to 3 weeks). For adolescents with a history of cocaine use, UAs must be more frequent—often at every contact—because 3 days after the last use, the screen may not detect cocaine. When the teen has a history of opioid or amphetamine use, the therapist must become knowledgeable about those drugs. It is essential for the therapist to have clear and correct information about the effect and duration of substances in the human body.

The MDFT therapist, as a part of the ongoing trusting relationship with the teen, will often say, "So, tell me what it's going to be," before conducting the screen. This interaction is significant because it offers the teen the chance to be honest about his or her use with an important adult. It sets the stage for future honest communication with parents and other important individuals in the adolescent's life. A major part of maintaining drug abstinence is moving from dishonesty to honesty about drug use.

When an adolescent's urinalysis shows that no drugs are present, it can pave the way for the adolescent and his or her parents to begin communicating differently. The case example of "M." illustrates the use of a urinalysis in an MDFT family session.

Case Example: M.

M. is a teen who, because of charges unrelated to his drug use, was confined to his house after 6 p.m. unless he was with one of his parents. A major theme of his family therapy has been trust and communication between family members, especially between M. and his parents. During a family session in the home, M.'s therapist worked with them on communication skills, but M. became sullen and refused to speak. Upset because his mother believed he had been smoking marijuana the day before, didn't trust him, and became angry at him, he then burst out angrily at her. M.'s mother replied that his eyes were red and that she had little motivation to trust him. The therapist worked with mother and son, then used the urinalysis as a way to reestablish trust among the family members. The therapist suggested that M. take a test to demonstrate that he is reliable and can be trusted to go to certain friends' houses after school. In this way, M.'s therapist indicated that she trusted him, believed he was telling the truth, and advocated for him with his parents. His parents, in the meantime, worked on establishing acceptable guidelines as to where M. would be allowed to go in the immediate neighborhood—this was their way of showing trust. Here, M.'s therapist supported the parents' need to establish those guidelines and know without doubt that their son was not using drugs. When the urinalysis showed no drugs were present, his mother kissed him on the cheek and expressed her relief, and M.'s therapist showed her pride. Using the urinalysis circumvented arguments and facilitated family agreement.

When the adolescent does not want to complete the screen, it is frequently because he or she was using. The therapist may simply ask, "Is that because it will show drugs are present?" or "Are you afraid of what the results might be?" Often teens will continue to stall by saying they cannot go to the bathroom or that they just went; usually they are afraid of the consequences when the results are known. At this point, the therapist will need to provide cups of water for the teen to drink and go on with the therapy session. After sufficient time and water, the therapist may ask the teen again, "So, what will the results be?" and encourage him or her to try going to the bathroom. If the adolescent continues to deny using and will not complete the screen, it may indicate the teen's overall distrust of relationships and a hesitancy to trust anyone in a situation where he or she may experience negative consequences.

With consistent encouragement and the knowledge that the therapist will not let up, the adolescent will complete the screen. Some teens will adulterate urine by adding water or other substances, which the temperature strip will indicate. The therapist may say, "You know, this temperature just isn't right; why don't you try again?" Once again, the teen may be reluctant, but sufficient time and water will encourage him or her to complete the screen. MDFT therapists have never had to request a screen more than two times.

When a urinalysis shows drugs are present, the therapist elicits the details of what happened: when did the teen use; what day and time and in what place; how much and what did the teen use; how many times; what were his or her thoughts and feelings before, during, and after; which friends were present; and most important, how could the use have been prevented. This detailed knowledge will help the therapist formulate ways of working with the teen and his or her family later on. The structure may include increasing 12-Step meeting attendance; greater parental supervision and less free time, including a more secure curfew; or brief residential treatment for stabilization. Another option may be more frequent check-in with a juvenile probation officer and department of justice sanctions; these are seen as last-chance efforts and often send more punitive than therapeutic messages to the teen.

The clinical chart is a powerful tool for the therapist with a teen in strong denial. It provides concrete grounds for discussing restrictions with the teen, and he or she, in turn, gains an understanding of why consequences occur and where he or she is in the treatment process. If an adolescent's chart consistently shows the presence of drugs, it focuses on the question of whether the adolescent is really considering stopping his or her drug use.

MDFT therapists offer teens the opportunity to tell their parents their UA results themselves. Again, in keeping with the philosophy that secrets are not a part of recovery, the adolescent is reminded that parents will know the urinalysis results and that this is his or her chance to be honest with them. When the adolescent chooses to tell his or her parents that the UA showed drugs were present, it gives the teen a different way of being in a relationship with his or her parents. Alternatively, the therapist may tell the parents the results of the screen during the next family session with the teen present and then work through the consequences in that context. However, if the therapist believes the parents' reaction will be extremely negative, then the therapist will meet with the parents separately to process their reactions before including the adolescent. The case example of "B." below illustrates using urinalysis results to help "B." with the details of the event and his mother with processing it.

Case Example: B.

B. is a teen whose father is a chronic, severe alcoholic in rehabilitation during the time of this session. B. had not used drugs for several months but had used marijuana, which showed up in his UA the week before. Initially during the individual session when the screen showed drugs were present, B. denied using and indicated that perhaps it was because he was in a car where someone else was using marijuana. After a second test showed that he continued to lie about using, his therapist explained that the tests do not lie and that he must have used drugs. B.'s therapist then worked with him on the concept of relapse, stating simply that it meant everyone would have to work harder to help him continue to recover. At that point, B. finally admitted using and shared the details with his therapist. This therapist's nonpunitive response allowed B. to begin a different kind of relationship with his therapist and deepened the trust between them. During the next session, B. said he had something to tell his mother but that she could not tell anyone. The therapist interrupted him and indicated that if he was agreeing to be honest, he could not extract promises beforehand.

The following dialog resulted from this case example.

Therapist (T): *We'll talk about that later. First, just tell her what you need to tell her.*

B: [head low] *I came up dirty.*

Mother (M): [sighs] *Why?*

B: [crying, looking down] *I smoked again.*

M: *With who?*

B: *With these girls from the pool. They were smoking. The day I had told you I was going to the pool before I met this guy. I went to the pool and they were smoking. I was getting friendly with them and then I got their phone number and they asked me if I wanted to smoke. And I told them no and then I told them, you know, that I was in a program* [sniffs] *and they went like that* [demonstrates with his hands, someone offering] *in front of me* [laughs nervously] *and then I was like, damn. And then I told them no, again, but then like they got up and went like this, you sure?* [puts hand in front of his mother's face as if offering her something] *Just hit one time.* [laughs] *I couldn't tell them no, again. So I hit it. And then they kept on smoking and then I stayed talking to them. I was like, nah, I can't smoke no more. And then when it came around again, I got it again. I smoked again. And I kept on talking to them and then I went home. And remember that was the day you saw something wrong with me. You told me, "What's wrong?" Then I went to sleep* [laughs nervously]. *Remember that was the day?*

M: *I had thought you weren't doing anything anymore.*

B: *And then I saw them again when I was with this guy. But this guy don't smoke. So I told him what happened, that I was smoking with them. And then like, 'cause I didn't want anyone in the family to know. You know everybody thinks I'm doing good. So in 3 weeks, they're gonna give me another drug test. To come out clean, it takes 3 weeks to get* [drugs] *out of my system.*

M: *You really have to want to stop smoking.*

B: *I know.*

M: *'Cause if you don't…*

B: *But I did. I was 3 months without smoking. Three whole months.*

M: *But I feel that the reason you weren't smoking was being here in the program.*

B: *That's probably true* [laughs].

M: *I mean that's… I don't know.*

T: *Let me ask you this, Bobby. When you were telling your mom, were you crying a little bit?*

B: *Uh huh.*

T: *Why? What were you crying about?*

B: [crying] *'Cause I know she, like right now, she said I was doing good.*

T: *So what are you feeling? Why are you crying about that?*

B: *'Cause I was doing good.*

T: *Hmm?*

M: *He wants to do good.*

B: *I was doing good.*
T: *Okay, so why are you crying?*
B: *'Cause now I know she don't trust me. She don't know if I'm gonna smoke again.* [sniffs] *I don't blame her 'cause she don't know; I don't even know.* [sniffs]
T: *Okay. You're making a really good point, okay. She doesn't know if you're gonna smoke again or not. And so she can't trust you and you said you don't even know. Right?*
B: *Yeah, I don't even know. I know I don't want to smoke again. That's why I'm hanging around this guy that doesn't smoke.*
T: *Okay.*
B: *So like, I won't.*
T: *Be tempted.*
B: *Smoke. And he's, like he's nice. I like him a lot. He don't smoke so I know that he won't tempt me to smoke. I don't know if like another girl will come around and make me smoke again.*
T: *Okay. Well, let's go back to just what you're feeling right now; that it's making you cry. I think you've let somebody down.*
B: *A lot of people. The whole family.*
T: *Who've you let down?*
B: *The whole family. That's why I don't want nobody to know* [laughs nervously].
T: *The biggest thing about addicts is that addicts use drugs, okay? But the second biggest thing about addicts is their secrets and lies. Addicts keep secrets and addicts tell lies. So my suggestion to you, Bobby, is not to get involved in secrets and lies, not keeping some big secret, okay? That won't help you.*

B.'s therapist then shifted the focus and began to work with B. on how important honesty and not keeping secrets are to his recovery. B.'s therapist processed with B. the kind of relationship B. could have with his mother. As a young man, not a little boy, he would need to be direct and honest with his mother and have a mature relationship with her, "telling the truth like a man." To help B. develop empathy for his mother and to acknowledge how B.'s mother was feeling, his therapist began talking with his mother about how guilty, terrible, and angry she felt when she knew B. was lying to her. His therapist helped B.'s mother reaffirm her love for B. Both mother and son then were able to work on having a different kind of relationship, in which B.'s mother screamed at him less and in which B. respected his mother enough to tell her the truth and be honest. B.'s therapist helped them think of new ways for B. to stay sober and learn from the situation. It was decided to address the relapse by conducting a new urinalysis in 3 weeks, increasing the frequency of AA and NA 12-Step work, and using sessions to focus on B.'s use patterns and sobriety. In wrapping up the session, the therapist and B.'s mother agreed to spend some time in individual sessions to focus on managing and coping with her frustrations. In this way, both mother and son agreed to work on making changes within their own way of coping.

T: *Have you known for some time that he doesn't tell you the truth all the time?*

M: *No.*

T: *And what does that make you feel like?*

M: *Terrible. I always tell him to tell the truth. It's better to tell the truth, 'cause once you lie, you have to keep on lying and lying and I know if I had to live like that, I couldn't.*

T: *Do you know, though, that he tells his dad some things that he doesn't tell you?*

M: *Yeah. I found that out in the meetings* [the Al-Anon meetings].

T: *Was that the first time you ever knew that?*

M: *Yeah.*

T: *And how did that make you feel when you found that out?*

M: *Terrible.*

T: *Why?*

M: *Because they don't tell me and then, I think I feel guilty because I'll start screaming and get mad and that's why they don't want to tell me.*

T: *I'm not sure that's why they don't want to tell, Rose. I don't know, I mean I'm not there so I don't know, but…*

M: *That's what they always say. That they can't tell me anything 'cause I'm always screaming.*

T: *Well, now that's a good excuse, but I'm not sure that's the truth. Because from what I've heard, their dad can get in a real fit sometimes when he's drunk. He goes on some real tantrums, doesn't he?*

M: *He gets really mad.*

T: *So if that was the truth, then they wouldn't be telling him either.*

M: *I really don't know why.*

T: *Uh hmm. Ask him why then. Ask him to tell you why.*

M: *Why?*

B: *'Cause we don't want to disappoint you.*

T: *Is that good enough, Rose? I think we need to know a little more about that. I want you to ask him to explain that to you.*

B: [laughs] *You're putting me on the spot today.*

T: [laughs] *Ask him to explain that, Rose. Please.*

M: *Explain that.*

B: [laughs] *I can't explain it. It just that that's the reason. We don't want to, that's it.*

T: *What? Come on, Bobby, we need a little more than that.*

B: [laughs nervously] *Nah, because, damn, you always give us everything we want and then we do something and we f___ up. So damn, we don't want to. We don't want to tell you what we did; you know our mistakes. That's why.*

T: *Then why can you tell your dad?*

B: *Because he's always making mistakes.*

T: *Ah, okay, okay, I think we may be onto something now. That's a big thing that you're telling me and that you're telling your mom, okay? Your dad is flawed so you can tell him your flaws because he has flaws, too.*

B: *Yeah.*

T: *But your…*
B: *She don't have no flaws.*
T: *She has no flaws. Okay, okay. So is that true, Rose? You have no flaws?*
B: *And if she does she keeps a really good secret.* [laughs] [everyone laughs]
M: *No, I'm not perfect, but I don't do drugs, I don't drink.*
T: *Okay, you don't drink and you don't use drugs.*
M: *The only thing I think is that I scream a lot.*
T: *Okay.*
M: *Because I'm always angry.*
T: *Uh hmm. Why are you always angry?*
M: *'Cause they're always doing things that they're not supposed to.* [begins to cry] *And I tell 'em do like this and do it the other way, I don't know, I'm just tired.*
T: *Uh hmm.*
M: *What can I do? I teach them the right way and then they keep doing the wrong things, so what can I do to teach them the right way? They want to do wrong, that's why I'm always screaming. And you're always screaming. No, if you would do it the right way, you'll never hear me scream. I don't have no reason to scream. And then they put that guilt on me all the time that I'm always screaming. You know you always do that.*
T: *So now what's making you feel so, what brought up those tears for you right now, Rose?*
M: *I don't know. I always feel guilty, I don't know why.*
T: *You always feel guilty?*
M: *I'm always guilty, I feel guilty 'cause they always put that guilt trip on me.*
T: *What's a guilt trip? That you're screaming too much, is that it?*
M: *Yeah, that I'm always screaming, that's why they keep telling me I need to…*
T: *Okay, but today, he told you that's not it.*
M: *I know.*

As the session progressed, the therapist worked with mother and son to begin to transform their relationship from one functioning around using to a healing ceremony. These interactions opened up a new way for B. and his mother to relate to each other.

Urinalysis is often a very important issue for parents. They frequently focus on drugs as the cause of their adolescent's problems and see abstinence as equivalent to cessation of problem behaviors and a return to a more "normal" life for themselves. A UA showing no drugs present allows parents to discover hope that may have been lost and assuages some of the intense fear and terror that they experienced when their adolescent's drug use spiraled. Whereas parents frequently want the problem "fixed," the therapist must work with the parents to help them understand that, given the nature of adolescent development combined with the family's history, recovery is usually a rollercoaster ride, not an incline leading to a plateau of positive behavior.

When an adolescent has not used for some time and then relapses, the parents frequently believe history will repeat itself endlessly. The therapist, together with the teen, if possible, must help the parents look at the circumstances that allowed the relapse to occur and to develop protective factors to prevent future drug use as much as possible. The therapist works with the parents to increase supervision and consider what other consequences may need to be enacted and give the parents hope that the situation is not completely out of control.

Use of 12-Step Fellowships in MDFT

The 12-Step fellowships (e.g., AA and NA) are a useful resource for the MDFT therapist both during treatment and after treatment ends (Nowinski, 1999). The 12-Step fellowships focus primarily on the symptom—alcohol or drug use—an area encompassed by MDFT's focus on the multiple-problem syndrome. The aftercare component for the teen is especially essential, and the 12-Step programs provide both a prosocial component and support for a drug-free lifestyle even after treatment ends. Therapists have also found adjunct meetings such as Alateen and Al-Anon helpful to both the adolescent and his or her family members.

Many adolescents in treatment state they dislike 12-Step meetings. They feel bored, have difficulty sitting still, and believe that they have nothing in common with "those old people" sharing their life stories in front of the group. Some of the difficulties are developmental; teens often have difficulty linking the common theme of addiction in the life stories of the adults with their own life stories. Many adolescents also have antisocial personality characteristics, magnifying their lack of empathy and contributing to denial of their drug use. Finally, most teens have not experienced the types of consequences that adult addicts discuss in the process of "hitting bottom."

When asked what they remember from 12-Step meetings, most teens will recall a number of things: receiving chips for sobriety milestones, slogans (e.g., One day at a time), and stories. These stories are often recalled most vividly, and they provide an entry point into the adolescent's point of view. The therapist may access this experience with questions. In sessions, the MDFT therapist continually reframes the stories that the adolescent hears, pointing out parallels with the teen's life, placing the story in a timeframe relevant to the adolescent, and describing possible use.

Out of the session, the MDFT therapist may attend an open meeting with the adolescent, using the events of that meeting later in sessions. Although the adolescent may continue to deny similarities between himself or herself and the members of AA or NA, over time and with continual reframing, the denial may begin to break down. Adolescents become more comfortable at meetings over time, particularly when the material is processed in therapy sessions. Encouraging adolescents to participate in the meetings, share, make acquaintances, and form friendships helps them see that the 12-Step meetings can be relevant and important in their lives even after treatment is over. In the case example of "L." below, the therapist attends a 12-Step meeting with the adolescent, using the time afterward to process the experience. She also works with the adolescent around relationship issues with his brother in the context of Alateen meetings.

Case Example: L.

L. is a 16-year-old Hispanic who used cocaine, crack cocaine, and marijuana regularly before treatment. During treatment, he has had occasional relapses, most involving a combination of marijuana, illicit alprazolam (Xanax), and alcohol. After a recent relapse involving use of marijuana, L.'s therapist attended his regular NA evening meeting with him. Although initially resistant to attending NA and somewhat angry about his relapse, L. was attentive during the meeting, nodding in agreement, and eventually relaxing toward the end of the meeting. On the way home, L. stated that he no longer felt angry and believed that attending NA meetings might actually help him. He discussed the cravings he had for marijuana and was able to connect feeling stressed and anxious with his desire to use. L. stated that he had not thought about the consequences of using, including possible violations of probation, and expressed fear of being detained. While discussing his relapse, he expressed shame and regret about the experience. L.'s therapist helped him continue processing what occurred in order to plan ways to avoid future relapses. She also gave him an NA pamphlet to read.

L.'s 13-year-old brother, J., is also actively using substances and often comes home high, moody, and irritable. L. frequently tries to parent his brother and attempts to convince J. not to use, with minimal effectiveness. L. also believes that his brother's use will not affect his own ability to avoid relapse. His therapist recommended that L. begin attending Alateen as a way to improve his ability to deal with his brother's use, and L. responded positively. After a period of time, L. indicated that he had difficulty identifying the relevance of certain slogans to his experience with his brother. However, he was able to express his understanding of the slogans "How important is it?" and "One day at a time." L. found the slogan "Let go and let God" difficult to apply. As a result, he continued to express ambivalence about attending, emphasized his need to try to influence J., and believed in his ability to stay clean without attending meetings. L. reluctantly agreed to continue to attend Alateen as well as his NA meetings, and his therapist continued to work with him on relational topics.

Access to 12-Step meetings can be challenging for an adolescent. Most adolescents will not go on their own to a meeting and if required to show proof of attendance may forge their attendance sheets. Often, parents are unable or unwilling to transport the adolescent to a 12-Step meeting more than once a week. In the majority of cases, the adolescent is transported by the therapist to the 12-Step meetings each week.

An alternative is having one meeting a week at the treatment site and one meeting off site. This is possible when adults are willing to give their time to lead a closed adolescent group as part of their NA/AA program. The adult leader coordinates the meetings, brings speakers, discusses current life experiences, and facilitates the group to approximate any other closed 12-Step meeting. It is sometimes difficult to begin a group through an institution, and the traditions of NA/AA maintain that groups should not be affiliated with professional organizations. Thus, members of the recovery community are the primary resource to MDFT therapists in this situation.

Initially, MDFT therapists had concerns about negative influences on adolescents in treatment attending the same meeting and getting to know one other. However, bringing the adolescents together can have a synergistic effect. The adolescents are able to process their shared experiences in the program as well as shared life experiences. MDFT therapists discovered that older adolescents began to mentor the younger adolescents and, in some cases, they had become social supports for one another. MDFT facilitates these peer-to-peer interventions with the full realization that sometimes grouping peers together in a psychosocial intervention program can produce iatrogenic results (Dishion & Andrews, 1995). Therapists are present at the NA/AA meetings to monitor this possibility.

Case Example: Dealing With Drug Use Directly in Session

The following transcript excerpts represent a good example of a situation in which there was an appropriate and strategic use of an immediate-results drug screen. The father in this family used 12-Step meetings to support his own recovery. When the adolescent is tempted to use, the therapist cites the father as a role model for coping. The session includes Emilio (E), age 17; his father, Mr. Ramirez (F); and the therapist (T).

T: *Welcome. Today, I told your son that I need to finish by 4 p.m., so we will have a little shorter session today, all right?*
F: *Yeah, it is very important that we are meeting today.*

The father's sense of urgency is positive; the therapist will want to find a way to use it later in the session. Urgency and motivation are related.

T: *What is going on, Mr. Ramirez?*
F: *Well, a lot of things are going on, not so much with the house, but with Emilio.*
T: *Aha.*
F: *He's not following rules; he's not following what he needs to do; and he is behaving like a little kid, I guess.*

This is a relapse. In the past few weeks, Emilio had been coming to sessions. The sessions were productive. Emilio was talking about school, his struggles to flee certain peers, his positive feelings about his girlfriend, and his difficulties in coping with his parents' divorce, which was being finalized as the participants spoke in this session.

E: *Didn't I go to school?*
F: *He was supposed to go to the dentist on Monday, we reminded him. It was very important to go to the dentist because the dentist*

is very mad because Emilio has already missed the appointment five times.

E: *Five times? It was only once.*

F: *And he is very upset.*

E: *Five times?*

F: *The dentist said that if he continues to miss appointments, he's not going to treat him anymore, so we told him that day to please go to the dentist and he did not go. My wife called me to the house; the cops called her to say that he went to the roof with his friend, Rick, the kid that was here.*

T: *I'm sorry, Mr. Ramirez, before you continue with the description of the event, that friend is the one that was here with the blue eyes, right?*

E: *No.*

F: *Yeah, he came over here when you were here that day.*

E: *No, he didn't. It was another kid.*

F: *Well, he was with Rick; they went to the roof. They were throwing bottles, so the neighbors called the cops to say that they were throwing bottles at their house. The cops were very upset, saying that they already have a complaint against Emilio.*

T: *What kind of bottles?*

E: *We were throwing rocks at each other. It was two people on the ground and two of us on the roof, but we are all friends, throwing rocks at each other, just playing around—so I don't know why they said throwing bottles.*

T: *Throwing rocks? Throwing bottles!?*

The therapist wants to make sure the father's present concerns are very much supported by developing focus and intensity about the event by recounting the small details.

E: *Yeah, throwing rocks at each other, just playing. Then we went to play basketball.*

F: *You know every time the cops call, it is very upsetting because the cops say that Emilio has problems again, and they say Emilio is in trouble again, and then yesterday he was supposed to come to see you right at 3 p.m.*

T: *Hmmm.*

F: *So I went by the house. He was talking to you on the phone and I smelled liquor in the house. So I went to his room and I found two bottles of vodka, and he was with his friend, Mike, the friend he used to have, who is supposed to be in the hospital rehabilitation program.*

E: *He was the one drinking.*

T: *So the reason you didn't come yesterday is because you were drunk, not because you were sick.*

The therapist does not want to let Emilio's missed session slide, certainly not now, because it is clear why he missed the session.

E: *No, I wasn't drunk. My friend Mike was drinking.*

F: *He wasn't drunk. His friend was the one drinking.*

E: *I was just chilling in the back.*
T: [to the father] *Weren't you supposed to authorize who is coming to the house?*

This resurrects a previous piece of work, when the father was put in charge of whom Emilio let enter the house and banning particular friends with whom Emilio has gotten into serious trouble in the past.

F: *Yes, that's right.*
E: *Yeah, that's why we got into a big fight yesterday, because I had people in the house.*
F: *Not only did he have people in the house, but he went to Mike's house, and Mike told him his probation was over. So he went to Mike's house, they got the bottles of vodka, and they were drinking in the house. I'm not saying he was drinking because the one that smelled like liquor was Mike, but he had two bottles of vodka in his room in his refrigerator, when he was talking to you on the phone.*
T: *Also, I'm sure you don't want to have alcohol in your house due to your own recovery, or have you already shared this issue with your son?*

The father's successful recovery makes him an ally in his son's treatment. The therapist takes every opportunity to highlight the father's success.

F: *Yeah, that's right.*
T: *So it is pretty serious, Emilio, because your father is struggling very hard to keep sober.*
E: *I know. I told him I'm sorry. I didn't drink, so that is why I told this kid to leave.*
F: *No, he left because I told him I was going to call the cops, to have him arrested, and the reason I didn't do it was because I felt bad for the kid. They would have arrested him for disorderly conduct in the street. He went running as soon as I told him I was calling the cops, but I was very upset. Emilio was supposed to be here at 3. He was supposed to be at the dentist at 4.*

The father's frustration with the relapse and his son's possible escalating problem behavior is something that the therapist must attend to and use in the session. Although the therapist did not plan to request a drug screen in this session, it is clear that, for the father's sake, and to cut through Emilio's relapse, a drug screen is indicated.

T: *I called at 3:05 because I know that Emilio is always on time. So what in reality was happening?*
F: *He was entertaining his friends in the house while they were drinking. They have no business being in the house, that was what happened. Whether he was drinking or not, I don't know, I was not there.*
E: *Didn't I tell you my throat was hurting? My mom knew my throat was hurting all day.*

F: *How come your throat hurts but it doesn't hurt too much to pick up a friend from school and bring him home?*
E: *I was not drinking.*
F: *How come it doesn't hurt to go pick up Mike at his house, when you are not allowed to be with him. How come it doesn't hurt you to be in the house with Mike getting drunk? That is what I want to understand.*
E: *So, okay, I was at the house.*
F: [to the therapist, exasperated] *I tell him he is in complete denial.*
T: *Do you think your son is doing drugs again?*
F: *I don't know. I think he needs to take a test.*
E: *I'll take a drug test, I don't care. I'm not taking drugs, not for a while now.*
T: *But you don't sound the same as 2 weeks ago.*
F: *Once he starts hanging around Mike, he doesn't go with his girlfriend anymore. He doesn't do schoolwork anymore like he used to.*
E: *Well, I still have good grades.*

The therapist has decided that this is the moment to conduct the drug screen.

T: *Okay, Emilio, please, we need to know what's going on. Are you using or are you not?*
E: *No.*
T: *So do you mind confirming this with a test?*
E: *No, I don't care.*
T: *Because I think your father is preoccupied right now and I see something that changed you lately. Two weeks ago you were making plans. You were out looking for a job.*

The juxtaposition of Emilio's recent progress with the need to determine whether a relapse is in progress (through the drug test) is important.

E: *I was going to get a job at the fair. I was supposed to. Then they said too many people signed up.*
T: *Could we do the drug test? I think it is important for your father. Then we can move on from here. Would you come with us, please?*

The therapist supervises the drug screen, and the results indicate drugs are present.

T: [upon return] *So Emilio, in the last 2 weeks you said you have not done any drugs.*
E: *No.*
T: *Of any kind?*
E: *No.*
T: *In the last month, in the last 30 days, you have not done any drugs of any kind?*
E: *No.*

T: *No heroin?*

E: *No.*

T: *No cocaine?*

E: *No.*

T: *No acid?*

E: *No.*

T: *No pot?*

E: *No.*

T: *Are you sure no pot?*

E: *Yeah.*

T: *Unfortunately, I need to disagree with you. The test is positive for marijuana, negative for methamphetamine, negative for cocaine, negative for morphine. And this is a very valid test.*

E: *I haven't smoked, so I don't know.*

T: *Emilio, that is why these tests exist—it's about fact.*

E: *It tells you how long it's been since I smoked?*

T: *Within the last 30 days.*

E: *Aha.*

T: *Emilio, we have a good relationship, and I think that if you would say to your father and to me, "I didn't want to acknowledge it, but I've been doing pot here and there," we can accomplish much more together today.*

The therapist tries to sidestep any debate about whether Emilio used drugs, inferring that other important things need to be talked about within the context of knowing that he, Emilio, had used again.

E: *I haven't smoked in 30 days.*

T: *Spending time denying it won't get us anywhere. I do trust these tests. It shows that you have used marijuana. The problem for me is that you cannot acknowledge that. In my clinical experience with kids like you, I was sure that you had done it because you are not the same as you were in weeks that you have not done drugs. It would be my word against yours, but now we have proof. We need to talk as three men here.*

E: *Yes.*

T: *We cannot be sitting here denying it. Say what is going on with you. Are you mad with your father or your mother? Are you confused?*

E: *I haven't smoked in 30 days.*

T: *I receive a training with these instruments, and I trust these results.*

E: *That means I smoked in the last 30 days?*

T: *Yes, within the last 30 days. I'm sure it happened in the last 2 weeks. Two weeks ago, when we met here in this office, you were by yourself, calm, relaxed, and thinking clearly.*

Linking a drug use state of mind to life events that are destabilizing or upsetting is important.

E: *I've been in my car with people smoking, but I didn't smoke.*

F: *They close the window and they fill the car with pot smoke; eventually, it is going into his lungs.*
T: *Mr. Ramirez, every kid in America who is caught by the police says I have not done anything, it was the other kid.*
F: *I agree with you.*
T: *If you are doing this again, why did you start? Are you mad or are you sad because of your parents' divorce? Are you mad with your mom? Do you get a lot of pressure from your friends?*

Emilio's progress was noted. The circumstances that promoted his relapse need to be determined.

E: *They're always fighting in my house every day, arguing, my parents and brothers.*
T: *That makes you nervous?*
E: *It is annoying.*
F: *Emilio, why do you carry a lighter everyday?*
E: *I smoke cigarettes.*
F: *I thought you don't smoke cigarettes.*
E: *Sometimes, I do; sometimes, I smoke cigarettes.*
T: *Since there are more fights in the house again, you started to feel more nervous again or more anxious, and you find that pot is calming you down a little bit? Be honest with me, Emilio.*
E: *No.*
T: *Are you attending AA meetings?*
F: *Yes.*
T: *How often?*
F: *I'm trying to go as often as I can, which has been only the weekends, because of my schedule and events with the family.*
T: *Your father is also dealing with a lot of problems and stress, so he knows he can be tempted to go back to his old habit. What does he do instead, Emilio?*
E: *He goes to meetings.*
T: *In the time that we have been working together, you showed to me that there is a very clear side in Emilio who wants to succeed in a drug-free life.*
E: *Un huh.*
T: *We need to finish today. So can you clearly acknowledge your relapse?*
E: *Yeah.*
T: *It would be pointless to fight the result of this test, right?*
E: *Yes.*
T: *So be honest with your father and say, yes, I've been doing pot. That should be it.*
E: *I don't think it was within these 30 days.*
T: *Okay, but you have done it, and it is clear that we need to work together harder now not to let you go downhill, okay?*
E: *Yes.*
F: *All right. Thank you.*
T: *Thank you very much.*

The session takes Emilio from denial of anything being wrong to a familiar zone for the therapist and family. Discussing the coping processes related to the divorce, the father–son relationship, and Emilio's ideas of what contributes to his difficult everyday circumstances are all more workable topics of discussion.

MDFT With Adolescent Girls

Female adolescent drug use has increased dramatically over the past 30 years. Consensus is emerging that the syndrome of female adolescent substance abuse is different from the well-recognized male pattern. Evidence from many sources provides a compelling argument that there are important differences between male and female adolescents, in particular, in patterns of comorbidity and family relationships. One member of the MDFT research group, Gayle Dakof (2000), is developing MDFT's approach to working with adolescent girls.

Drug-using girls referred for treatment not only use drugs and engage in externalizing behaviors as extensively as do their male counterparts but also are distinguished by a higher level of internalized symptoms and family dysfunction (Dakof, 2000). It appears that girls get a double dose of symptoms—the internalized symptoms more common in adolescent girls regardless of drug use and the externalizing symptoms prevalent in drug users regardless of gender. In addition, families of substance-abusing girls show more conflict and less cohesion than families of substance-abusing boys.

The family problems and internalized symptoms that characterize female adolescent drug abuse are illustrated in the following quotations from two girls. First, speaking about family relationships, Grace, a 16-year-old, non-Hispanic white teen, discusses why she doesn't feel close to and trust her mother:

> *When I was 14 years old, my mom came home from work early. She found me and some of my friends at home. She freaked out especially because of the guys. The next thing I know, that night I'm on a plane on my way to live with my dad. It was a lot of emotional stress. I didn't know what I had done wrong. I was confused. I didn't know. They didn't tell me. I didn't go to school for a couple of months because they couldn't get all of my records. It was hard because we lived in a place with no hot water, no shower, no kitchen. I hardly ever talked to my mom. That was over 2 years ago. Every once in a while, I would call my mom and beg her to take me back 'cause it was bad with my dad. He wasn't interested in me. He had a girlfriend. He'd beat me. I ran away a lot. But my mom always said no, until this last time. Well, I was living on my own for almost 2 months. I slept at friends' homes or in abandoned buildings.*

Next, Hope, a 16-year-old African-American girl with both serious depression and a conduct disorder, talks about her forsaken dreams and hopelessness about the future.

> *I'm not used to smiling. Never! Everybody always say, "Why you so sad lookin'?" I say hey, that's me. I always look sad. I always wanted to be a teacher. Everything changed around because I been locked up. I wanted to be a lawyer. I wanted to be a judge. I wanted to be a teacher. I'll probably fail in school again. The teachers are going to fail me again. I hope I make it to 20.*

These brief clinical portraits reveal why treatment should occur at both individual and family levels. Clinical and theoretical discourse on female adolescent development and psychotherapy with girls and women suggests focusing on relationships in treatment (Chodorow, 1978; Gilligan, 1982; Miller, 1976). With female adolescent drug abusers, in particular, this focus on relationships may be most beneficial in the realm of family relationships.

When working with girls, it is important to strike a balance between individual work on the adolescent's internalized symptoms and family work to address conflict. Adolescent girls and their parents often have differing views about which of these issues is more important (Dakof, 2000). Adolescent girls express more concern about family conflict, whereas their parents are first concerned with the girls' internalized symptoms. It is extremely important, in attempting to maintain engagement of all family members, to address both of these areas in treatment.

Cultural Theme Interventions

When interventions are tailored to individual adolescents and families, racial and cultural issues must be taken into account. MDFT treatment development efforts have included a focus on the use of cultural themes to enhance the engagement of African-American teens. During the past few years, the CYT program has been focusing on special engagement methods for Hispanic teens and families. The cultural theme engagement involves (1) therapist activity within multiple systems of the adolescent's life; (2) an emphasis on facilitating active adolescent involvement in treatment; (3) the use of popular culture, including the music of the adolescent's culture; and (4) extensive discussion of salient cultural themes (e.g., with the African-American teens—cultural mistrust, anger and rage, alienation, respect and disrespect, spirituality, the journey from childhood to adulthood, racial socialization, racism, and hopelessness). MDFT therapy is a means to help adolescents prepare for the next phase of life. The therapist begins this process by first accessing the day-to-day details of the adolescents' street lives. As an adolescent tells his or her story, the therapist is able to exert a positive socializing influence based on that story. The therapist is then able to involve prosocial adults in the adolescent's life as mentors, particularly males if the adolescent is also male.

African-American adolescent males are influenced by both the mainstream American culture and a traditional black or African-American culture (Boykin & Toms, 1985; Phinney & Devich-Navarro, 1997) within a youth or adolescent subculture embedded in street culture. For some adolescents, this street culture has antisocial connections. The culturally specific family therapy method presented here attempts to take into account all the interconnected cultural influences that affect these youth.

Articulating personally meaningful topics and treatment aims, focusing on the self and the teenager's personal story, and taking the therapeutic stance of being an ally to the adolescent are key in-session behaviors for the therapist. For example, using the music of the adolescent's culture within the therapeutic context helps adolescents to discuss areas of their lives to which the therapist otherwise would not have access more easily.

> **John (J):** *The only reason why I used to do marijuana is 'cause I heard rappers like Snoop Doggy Dogg say they used it.*
> **Mother (M):** *Are you going to listen to a record?*
> **J:** *Yeah, that's how it is.*
> **M:** *You'd rather listen to a record than listen to what I've been telling you?*
> **J:** *That's how it is, you can ask anybody.*
> **Therapist (T):** *People are doing a lot of stuff out there. It's not just because of the rappers.*
> **J:** *It's because of the rap.*
> **M:** *It's because of what you want to do from the beginning.*
> **J:** *No, it's rap. Snoop Dogg sounds better than you.*

In this example, the adolescent revealed that the rappers "sound better" than his mother's attempt at influence. In the next case, the therapist finds that the music helps the adolescent specify aspects of his world that frighten him. The young man (M) brought in a tape of a rapper that details his stealing. The young man stated this after the tape concluded:

> **M:** *People know that if they see a car full of people… well anytime you see a car full of people, and they don't look familiar, and they have music like that on, you know somebody's about to get shot up. It happened to me like that.*

Following this statement, there was a discussion about the young man's life on the street. The adolescent talked about getting robbed and the fight he initiated in retaliation the day after being robbed. The music that these young men enjoy speaks volumes about their experiences and their views of life.

The therapist tries to teach the adolescent new and necessary skills (e.g., anger control, bicultural efficacy) and to build new relationship bonds (or reestablish old connections) with caring family or community members. These connections help maintain the positive socialization influence of therapy, and they also assist with the maintenance of skills the adolescent acquires in treatment.

The transition into adulthood is relevant for all adolescents, but the theme of the "journey from boyhood to manhood" is particularly applicable to the transition experienced by African-American male adolescents. The focus on the journey from boyhood to manhood helps define therapy as the context within which the adolescent inventories his skills and preparedness for manhood. The theme is explored in discussion. What is manhood? What skills does the adolescent need for survival in the mainstream world? On the street? How does the adolescent view the street as being a part of his identity as a man/black man? Central to these intentional, focused discussions are assessments of the modeling or mentoring interactions present or absent in the teen's life. For adolescents who say they have no mentors, attention moves to how mentoring experiences might be established.

The therapist (T) inquires about prosocial mentors. In the following case, the teen's (R's) father is incarcerated and, because of the adolescent's extensive drug use history, his mother is planning to throw him out of the house on his approaching 18th birthday. Ultimately, this therapist has the goal of including the older male family member referred to by the teenager in treatment.

> **R:** *I'm going into the Marines because I know that they will help me get my degree.*
>
> **T:** *Now, you know someone who was in the Marines previously, don't you?*
>
> **R:** *Yeah, my uncle. He's married to my dad's sister, and he lives about 40 minutes away.*
>
> **T:** *Now, did he help you set up the meeting with the recruiter?*
>
> **R:** *No, but he's real nice. It's just that, I mostly call him when I need something.*
>
> **T:** *Do you feel that you've burned your bridges?*
>
> **R:** *No, but when I ask people for something, I feel like I owe them. When I was little, he used to buy me clothes and help me in school. He talked to me about men stuff. He was like a mentor for me. He's real nice.*
>
> **T:** *What happened?*
>
> **R:** *It just broke off, he got busy. I like being around him because he's real proper. He's not like the people I usually see. Like he don't listen to rap. He listens to jazz.*
>
> **T:** *Okay, so let's talk about your aunt and uncle. I'll tell you why I'm asking. A mentor is important for a 17-year-old kid. And if your uncle is good to you and you like him, then this might be somebody who you can get some positive stuff from.*
>
> **R:** *Yeah.*
>
> **T:** *Do you have his phone number? Maybe I can call him and the three of us could meet together and see what we could arrange. You can invite him or I'll invite him. He sounds like the kind of person who would be happy to know that you thought of him as a mentor.*
>
> **R:** *Yeah, now when he comes here, watch him. Watch how he acts. I would like to be like him.*
>
> **T:** *I would like to help you do that.*

Plans are set in motion to help the adolescent reestablish this prosocial and supportive connection with a previously supportive man who can help with the teen's goals of joining the Marines and staying drug free.

In other cases in which men are not accessible, church groups, rite-of-passage programs, or job-training initiatives are used to assist with the processes of emotional support, skill development, and learning values.

When specifics are uncovered about the antisocial influences in a teen's life, it is important to discuss the developmental implication of these influences. In a 1994 National Public Radio (NPR) broadcast segment, titled "Jail Seen as Rite of Passage by Many" (Hinojosa, 1994), youth talk about the importance of "becoming a man" in their street subculture. The following is an excerpt from the NPR broadcast:

> For many young men in this country, it is not going to college or going to work but going to jail that has become something of a rite of passage. The United States has one of the highest incarceration rates in the world. On any given day, one-and-a-half million people are behind bars, most of them men. It's becoming a common, accepted, even welcome experience in some neighborhoods.

To counteract these street values, interveners should openly and frequently reinforce for these youth the positive developmental outcomes that may be culturally consistent but counter to traditional expectations for adolescents (Burton, Allison & Obeidallah, 1995; Burton, Obeidallah & Allison, 1996; Stack & Burton, 1993). Some of these alternative, culturally sanctioned outcomes may include acting as peacemaker between rival street gangs, taking responsibility for an older grandparent, helping community members and parents with the parenting of younger African-American boys, or simply accentuating the acquisition of skills to stay alive on the street while resisting involvement in antisocial peer culture (Burton, Allison & Obeidallah, 1995).

Tutoring and job-training programs are examples of well-organized, prosocial, future-oriented, competence-producing contexts. (See Interventions To Improve School Behavior and Academic and Vocational Functioning on page 136.) Once adolescents of any culture have found a context to learn these skills, a core clinical challenge is to assist them with the process of learning to "role switch"—to use the skills needed to survive in one culture only in the context of that culture and vice versa (Boyd-Franklin, 1989; LaFromboise & Bigfoot, 1988; Pinderhughes, 1982). Bicultural competence training is recognized as an essential component of African-American success (Banks et al., 1996; Demo & Hughes, 1990; Fordham & Ogbu, 1986; Phinney & Chavira, 1995).

In the next example, a young man (JD) reveals an aspect of himself that he uses on the street. His father (D) insists that he "control" that side of himself in other environments. In response, the therapist (T) reshapes the idea of control into the more competence-oriented concept of role switching.

T: *Part of why we are going into the past is so we can get out of the way anything that might be causing what we see now. JD, can you say a little more about this street side?*

JD: *I've got to take care of myself and I just let that take over. If somebody says something to me, then I just let that street side kick in. See, I can control it sometimes, but like it just gets out of hand.*

T: *Dad, you're shaking your head. What's that about?*

D: *He can't control it.*

JD: *I can control it kind of.*

D: *No, he can't. He even said that if someone says something wrong to him, he goes off. And I try to explain to him that on my job people say wrong stuff all the time. Probably worse stuff than is said to him. You've got to learn how to use this* [points to his head], *'cause when the street side takes over, one day that could be it.*

T: *Let's try to figure out what goes on with this street side. Like how it serves you or doesn't serve you. Like how it may work for you in some settings, but not in other settings—and maybe not in the broader scheme of what you may want for yourself.*

JD: *See, the street side works when like something happens. But when I'm in school, it don't help 'cause it comes out and I get suspended and that makes me miss some of my schoolwork.*

T: *Is that something that you want to get some help on here? I mean working on how you use the street side?*

JD: *Yeah, and working on my attitude.*

The therapist raises the topic of using these skills only in settings other than on the street where they will be useful (Schinke et al., 1988).

Risky Sexual Behavior Interventions

An overarching goal of MDFT is to promote adolescents' healthy development including their sexual behavior. Interventions in this area focus on the adolescents' taking responsibility for their sexual practices, particularly in terms of protecting themselves from contracting HIV and sexually transmitted diseases (STDs). Early sexual activity and risky sexual behavior, pregnancy, and sexual acting out are common among adolescents with behavioral problems, and adolescent drug abusers appear to be particularly at risk (Deas-Nesmith et al., 1999; Langer & Tubman, 1997). MDFT interventions addressing sexual behavior are delivered in a structured, educative manner through the use of an HIV prevention workshop and in a less structured manner during the therapist's individual interactions with the adolescent.

The educational portion of the adolescent HIV prevention module may be provided in cooperation with an existing community program. It is essential that the educational material presented be appropriate for the adolescents' developmental level, as well as the characteristics of the particular adolescents in the MDFT program. One way to ensure such a specific orientation is to pilot and refine the workshop format and content in conjunction with the community agency. Workshops facilitated by peer leaders seemed to be beneficial, especially when the option was provided for the adolescents to later become leaders themselves. Topics of this educational component should include STDs, basic information about HIV/acquired immunodeficiency syndrome (AIDS), decision-making skills regarding sexual behavior, communication skills, discussion of love and relationships, peer pressure with regard to sexual activity, and techniques for safer sex.

Key Concept:

Therapists creatively modify local resources to meet the needs of the adolescents with whom they work.

All educational HIV prevention sessions should be interactive and contain fun activities to keep the youth engaged in the education and skill-building process. After the workshops, each adolescent may be asked to engage in outreach activities, including making presentations about safer sex to other adolescents. MDFT therapists have found that the adolescents are very engaged in these sessions and create a positive dynamic within the group. Therapists attend the workshops with the adolescents, and the adolescents do not seem to hold back any information in their therapists' presence. One extremely powerful component of this type of educational experience can be inviting a teenager or young adult who contracted HIV from heterosexual contact and has become symptomatic to speak to the adolescents about his or her experiences. Having this individual meet with the adolescents helps make the issue more real for them and may combat their belief that only gay men or injecting drug users contract HIV.

For adolescents who are currently sexually active, it is important to make consistent inquiries about their use of condoms, reminding them of the risks involved in not using them. These persistent reminders are pertinent because most of the adolescents' parents do not discuss such issues with them on a regular basis. MDFT therapists also help to arrange for female teens to go to Planned Parenthood for a pelvic exam and to explore birth control options.

The adolescents tend to be comfortable with these types of reminders and discussions, and they also seem to be comfortable in accepting the condoms that the therapists may distribute. These adolescents have grown up with the specter of AIDS, and they know that it is a life-and-death issue. They do not always behave responsibly, however, because of their developmental feelings of invincibility and their tendencies toward impulsivity. Another issue that contributes to the inconsistency between their seeming awareness of AIDS and their sexual risk-taking behavior is that even though they may know teens who are HIV-infected, their peers are typically not yet symptomatic. Not seeing their friends or other teenagers with the actual symptoms of AIDS makes the danger seem less real to them.

Helping adolescents move toward maturity, toward understanding and accepting the responsibility for self-care, is a key component of the MDFT model. This message—that they must take care of themselves and accept responsibility for their own health and own lives—is the same message that is communicated to them about their drug use.

Overall, the most important emphasis in terms of adolescents' sexual behavior is that it really is about life and death, as is drug use. (See Parenting Relationship Interventions on page 107.) The HIV issue, however, is an area in which the therapist can approach adolescents from a life-and-death perspective, and they know it is true. The therapist can then tie this work into other aspects of the adolescents' move toward health.

Multimedia Interventions

In attempting to gain access to the adolescent's world, the therapist uses psychoeducational videos, popular films, music, and written or Internet materials to facilitate discussion of both general topic areas and the personal experiences of the adolescent.

During the first stage of therapy, the use of multimedia resources assists the therapist in broaching sensitive topics with the adolescent. Because these types of media tend to be more interesting to the adolescent than simple verbal exchanges, they typically generate more interest in the subject matter. Discussion of topics raised through watching a movie or reading a story, and therefore not obviously and directly related to the adolescent, may also provide a measure of comfort. Once the therapy moves into the second stage and the relationship between the adolescent and therapist is stronger, these media can be used to help adolescents express more intense emotions and concerns in a creative, productive manner. The therapist may encourage the adolescent to bring in his or her own music or a particular movie that has captured his or her attention. At this point, the resources become catalysts for emotional exploration and expression.

A number of psychoeducational videos are available that target high-risk adolescents (e.g., *Straight Talk* [Substance Abuse and Mental Health Services Administration, 1993]). Similar films that target recovering adult substance abusers (e.g., the Beat the Street series [Boundy, 1996]), as well as televised documentaries or specials (e.g., *Lords of Chaos: Dateline Special* [Shapiro, Pepper & NBC News, 1999]), may also be appropriate. The videos most likely to hold the adolescent's attention are those in which the main characters are teenagers who seem sincere and realistic in their portrayals of the consequences of drug use and, if applicable, the manner in which they found a way out of the drug-using lifestyle.

The use of popular films in therapy has gained increasing support in recent years (e.g., Hesley & Hesley, 1998). MDFT therapists have found such films as *Dead Man Walking* (Gramercy Pictures & Robbins, 1995), *Good Will Hunting* (Miramax & Van Sant, 1997), *Boyz N the Hood* (Columbia Pictures & Singleton, 1991), and *Basketball Diaries* (Polygram Video & Kalvert, 1995) helpful.

MDFT therapists tend to reserve the use of music with the adolescent for the middle stages, after a relationship has been established. An adolescent's choice in music, and the discussion that may accompany reviewing the lyrics, can be intensely personal. The case example below illustrates the use of music in individual work with an adolescent in MDFT.

Case Example: J.
J. is a 14-year-old teenage male whose brother has been referred for MDFT treatment. The therapist also does individual work with J., and she has noticed that J. has difficulty with the traditional, face-to-face therapy session. When he and the therapist are engaged in another activity (e.g., playing a game, eating lunch), he becomes

much more talkative and seems relatively at ease. One week, J. was suspended from school and spent considerable time at the therapist's office. He asked whether he could bring in some favorite CDs, and he and the therapist printed out the lyrics from an Internet site. They listened to a few songs, then began talking about two songs in particular, both of which had a spiritual theme. One was titled "Damien" (DMX, 1998) and described some of the temptations of street life. J. identified with the song because he felt it was a picture of his own life, which he described as "hellish." The next song on the album, "Prayer" (DMX, 1998), talked about the pull the rapper has experienced between right and wrong and deciding which path to follow. This song was particularly poignant for J., who experiences some ambivalence about religion and faith. As the therapist described it, the music provided her with a window into the adolescent's world.

MDFT therapists experiment with a variety of creative and expressive outlets with the adolescent, including writing or journaling; the use of teen-centered books, magazines, or Web sites; and audiotaping or videotaping. The therapist encourages the adolescent to tell his or her story in any medium that is comfortable for him or her, and this storytelling can be facilitated by reading or hearing about the experiences of other adolescents. To encourage these efforts, the MDFT therapist provides the adolescent with computer access whenever it is needed. Invaluable resources can be obtained through the Internet.

One resource that MDFT therapists have used is the series Teenage Diaries (Richman, 2000). NPR describes this series as "a new kind of oral history." NPR trains the teens to be radio reporters and provides them with a tape recorder for a period of 3 months to a year. The adolescents then keep an audio journal, usually collecting more than 20 hours of tape. NPR editors collaborate with each teen to compile radio documentaries for broadcast on the *All Things Considered* program. NPR also maintains a Web site on which listeners can replay these stories (www.radiodiaries.org/teenagediaries.html). Instructions from NPR on how to begin a similar project with local teenagers are being compiled, and MDFT therapists have already begun encouraging their adolescents to record their experiences in a similar way.

MDFT therapists also use videotaping with adolescents, encouraging them to "tell their stories" as if they were on television. The information the therapist may glean from this storytelling is invaluable, and the telling in and of itself can be immensely therapeutic for the adolescent.

Another useful resource is the Youth Communication Web site (www.youthcomm.org/) (Hefner & Brown, 2000), a fairly new site that helps teens develop their skills in reading, writing, thinking, and reflection.

The multimedia module of MDFT represents a useful, practical tool that, at its best, provides a window into the adolescent's world consistent with MDFT's philosophy of approaching and developing a relationship with the adolescent individually.

Spirituality

Spirituality (belief in a higher power, God, goodness, love, or morality) is a topic broached only after an established relationship exists between the adolescent and therapist. Many adolescents who have entered treatment following detention have had contact with spirituality or the Bible because of ministry groups operating in detention centers. Many teen girls in treatment have been involved with and attended a church in the past, whereas for most teen boys it is their families who have been involved with a church.

Based on this type of intervention, it is possible to determine where the adolescent is in his or her interest in spirituality. Some adolescents are ready to make a link to a church, others to meditation, and others to the serenity prayer and the 12-Step concept of a higher power. But in all cases, the MDFT therapist proceeds carefully, not selling church, not selling a "preachy religiosity," but inquiring into the world view of the teen.

Spirituality can be a link for the adolescent to feeling good about himself or herself rather than feeling good primarily through material possessions. The MDFT therapist can facilitate and reframe the process, commenting that he or she sees the spirituality, the goodness in the adolescent, and asking whether the adolescent can see it in himself or herself and project it to interactions with others. Addressing spirituality with adolescents can help them learn how to find the better life, the inner serenity, the comfort found in connecting to something bigger than they are.

Psychiatric Consultation and Psychotropic Medication Management

Many adolescent drug abusers exhibit comorbid symptoms that require psychiatric intervention, including the use of psychotropic medications. As with every component of MDFT, psychiatric interventions must be integrated into the adolescent's overall treatment plan and be based on a comprehensive evaluation of the adolescent. The adolescent should be seen by a child and adolescent psychiatrist who has experience in working with substance-abusing teens. It is also important that the psychiatrist share the MDFT philosophy of not overmedicating adolescents and that he or she be willing to work closely with the therapist, the adolescent, and the family to monitor the medication "fit" for each particular teen. The therapist and consulting psychiatrist are in regular contact about compliance, dosage, and matters pertaining to the medication's impact.

Adolescents who exhibit symptoms of comorbid disorders should undergo a comprehensive psychiatric interview and medication evaluation immediately on intake into treatment. Occasionally, adolescents will not exhibit comorbid symptoms until a few weeks into treatment, after the illegal drugs they had been using are out of their system. In such a case, the adolescent should be referred to a psychiatrist as soon as the comorbid symptoms become evident. The psychiatric evaluation should address the adolescent's history and presenting concerns and should conclude with a diagnosis and, if applicable, a medication recommendation. The most common reasons for medication in this population are depression, anxiety, attention deficit/hyperactivity disorder

(ADHD), and bipolar disorders. Specific medication guidelines should be developed in consultation with a child and adolescent psychiatrist.

For adolescents who already have some psychotropic medication prescribed at the time of intake, the following steps have been recommended (obviously these guidelines are only illustrative):

1. If a benzodiazepine has been prescribed for anxiety and the need for treatment of anxiety is evident, the medication will be tapered off and replaced with a selective serotonin reuptake inhibitor (SSRI) (e.g., Paxil, Zoloft, Prozac). If the need for the treatment of anxiety is not evident, the adolescent will be withdrawn from the medication. Benzodiazepines are discontinued because of their addictive qualities in this population.

2. If a tricyclic antidepressant has been prescribed, it may be maintained initially, but it will be replaced by another antidepressant later in treatment. Tricyclics will be discontinued because they may be lethal and have many side effects.

3. If methylphenidate (e.g., Ritalin) has been prescribed for ADHD, it will be discontinued because of its value on the street and the potential risk that it will be sold on the street. Methylphenidate will be replaced by bupropion (Wellbutrin) or pemoline (Cylert). If neither buproprion nor pemoline is effective in reducing ADHD symptoms, modafinil (Provigil) may be prescribed.

4. If lithium has been prescribed for bipolar symptoms and there is no prior history of alternative medications, it will be replaced with divalproex sodium (Depakote). Lithium is not the medication of choice because of side effects (tremors, acne, and weight gain). If bipolar symptoms with severe and indiscriminate aggression are present, carbamazepine (Tegretol) should be considered first.

For adolescents who come to intake without a prescription for medication, the following steps will be followed:

1. If recent use of alcohol or cocaine is known of or reported by the adolescent, a waiting period to clean out the system is necessary rather than treating symptoms resulting from its use.

2. If there is no recent substance use and symptoms of depression are evident, the adolescent should start on an SSRI.

3. If there is no recent substance use, bipolar symptoms are present, and there is no prior history of medications other than lithium, divalproex sodium (Depakote) should be tried. Lithium is not the medication of choice because of side effects.

4. If bipolar disorder is present with severe and indiscriminate aggression, the first consideration is carbamazepine.

5. If obsessive-compulsive symptoms are present, it would be wise to start the adolescent on an SSRI.

After completing the evaluation, the psychiatrist should contact the MDFT therapist to discuss diagnostic impressions, any medications prescribed, and any apparent obstacles to implementing the medication regimen. The therapist should then review with the adolescent and his or her family the psychiatrist's recommendations and issues of medication compliance. MDFT therapists have typically found that the adolescents' parents differ in their opinions about their children's receiving medication. Some are desperate for a "cure" for their adolescent's behavior and may hope for a "magic pill." Others resist the use of medications if they do not agree with the diagnosis, as is sometimes the case when a child has been diagnosed with ADHD. Parental attitudes and compliance with the adolescent's medication regimen vary. The therapist can elicit parents' assistance in monitoring the adolescent's medication side effects and whether the symptoms are abating. There is, on occasion, a parent who adamantly resists placing his or her child on medication. The case example below is such a case.

Case Example: P.

P. is a 17-year-old adolescent male who, on intake, exhibited several depressive symptoms such as hypersomnia, loss of appetite, dysphoric mood, and irritability. The psychiatrist evaluated him and recommended that he begin taking Zoloft to alleviate these symptoms. The teen's father was concerned that his son would replace his reliance on illicit drugs with a reliance on psychotropics. The father had relapsed immediately before MDFT treatment for his son began, was also exhibiting depressive symptoms, and refused to take medication himself. Over time, as the therapist built a strong alliance with the family and the father began to trust her opinion, he sought psychiatric treatment for his own depression, and his depression slowly lifted. The father's improvement affected his son's well-being, and the father allowed P. to begin taking medication for depression.

Following the initiation of psychotropic medication, it is important that the psychiatrist monitor its effectiveness, compliance, and possible side effects. Meetings should take place weekly when the medication is initially prescribed (for approximately the first month), then monthly throughout treatment. With SSRIs, in particular, adolescents may not comply with their medication schedule. It typically takes a month before an adolescent notices changes in response to the medication, and these medications have side effects that are particularly unpleasant (e.g., erectile dysfunction, increased appetite, nausea). Additional reasons for noncompliance include the stigma of being labeled or simply forgetting to take the medication. Parental psychopathology and disorganization in the home are often linked with noncompliance as well. One way to address this issue is to have the school nurse dispense the medication during school hours. This requires a signed order from the psychiatrist. It is essential that the MDFT therapist also monitor the medication's side effects by asking the adolescent about it during their frequent contacts so that modifications can be made immediately. Otherwise, the adolescent may simply discontinue the medication without mentioning it to the therapist or the parents. The adolescent should be encouraged to report any side effects to the therapist immediately.

The therapist should meet or talk with the psychiatrist biweekly to review medication management and discuss crisis stabilization issues.

A critical aspect of treatment with this population is establishing a set of strategies for handling crises, especially for teens who demonstrate serious deterioration. MDFT therapists should become familiar with local mental health resources so that the procedure for dealing with crises can be delineated at the very beginning of treatment. There tend to be two situations that could require more intensive interventions: suicidality and physical violence.

Any adolescent who is judged to be at risk for suicide should be transported to the local community adolescent mental health crisis unit. Depending on the crisis unit's assessment, the teen should be returned home and taken to MDFT treatment (minimal risk), kept in the hospital for 1 to 3 days of observation (moderate risk), or hospitalized for 1 to 2 weeks (severe risk). In any case, treatment should continue with family sessions focusing on the issues that contributed to the adolescent's suicidal symptoms. The adolescent should then continue treatment when released from the hospital.

For the vast majority of drug-abusing youngsters, an intensification of the intervention dosage is sufficient to survive most crises within the family. In those cases in which the situation is exceptionally intense or dangerous, a period of respite should be arranged for the family members. One way to achieve such a respite is to work with the extended family to arrange for one of the at-risk members to stay with the extended family for a short time, although all members continue to be active in therapy and work through critical family issues. In cases in which no family members are available, therapists may use community shelters where the adolescent can stay in a nontherapeutic but safe environment. Joint therapy sessions should continue during this period of respite, providing continuity to the treatment.

Common crisis stabilization methods can be counterproductive because they derail the ongoing therapy process by pulling the adolescent and family out of treatment and into a separate crisis management facility (which has the sole aim of stabilization). The fundamental goals of the strategies presented here are to keep the adolescent and family safe through the crisis and to ensure continuity in therapy.

Overall, the adolescent module is characterized by efforts to engage adolescents in therapy, enter their world through a variety of means, and form an alliance with them to better effect change.

The Parents and Other Family Members Subsystem Module

Goals

- Build a therapeutic alliance with a parent
- Create a collaborative agenda
- Establish a developmental–ecological framework
- Facilitate parental commitment
- Prevent parental abdication
- Facilitate an improved relationship or improved communication between the parent and adolescent
- Increase knowledge about and effectiveness of parenting practices (e.g., limit setting, monitoring, appropriate autonomy granting).

Rationale

The family environment and parenting practices make unique and critical contributions to the development of adolescent competence or deviance.

Procedures

- Meet alone with the parent.
- Address parental frustration and despair while engendering hope, renewed commitment, and change.
- Understand the parent's beliefs and emotions about, and philosophy of, parenting.
- Assess competence in key areas.
- Help the parent create a new relationship with the adolescent.
- Help parent address personal developmental issues, take care of himself or herself, and manage relationships with extrafamilial agencies and institutions, when indicated.

Convincing parents of the essential premise that they can be helpful and influential in their teenager's life is a major task of subsystem work with parents. The goal is to interrupt the cycle of defeat, desperation, and distance that parents experience and to rekindle their hopes, dreams, and aspirations for their teenagers. They should not take on every issue but instead "choose their battles" with discretion. This choice involves defining the realms in which they can and cannot influence their child.

Parents are in charge of reestablishing a developmentally appropriate family environment; to achieve this, family management practices must be reviewed, as well as the family's history. Concomitantly, parents must also accept their need to confirm and assist in fostering the development of their teenager. A central challenge is how to make parents emotionally available to their teenager after all that has happened. This is very difficult. A therapist tries to resurrect some of the parents' previous levels and feelings of love and commitment for their child. If these are not there or are inaccessible, the therapist tries to create them anew, most frequently by emphasizing the dire straits their child is in and convincing parents that they are vital to accomplishing necessary changes. Sometimes, recognizing one's credibility as an authority or expert or citing evidence from research studies can be employed to remobilize parental commitment. Studies indicate that changes in parenting practices are possible, even with adolescents who are affiliated with drug-using peers and disconnected from prosocial institutions such as school (Bank et al., 1991; Dishion & Andrews, 1995). These changes in parenting are associated with decreases in the drug-using and antisocial behavior of youth (Schmidt, Liddle & Dakof, 1996; Steinberg & Levine, 1994). The quality of a teenager's relationship with his or her parents has been found to be the most powerful protector against deviant behavior and problems in development (Resnick et al., 1997). As in other arenas of assessment and intervention (e.g., adolescent development, neighborhood influences [crime, drug availability]), MDFT uses research-based knowledge about those aspects of parenting that promote prosocial development (Liddle et al., 1998). A number of treatment studies have shown that modifying parents' personal and marital distress can improve their problem-solving and communication skills and that these changes are associated with reduction in behavioral problems in their children (Dadds, Schwartz & Sanders, 1987; Mann et al., 1990; Miller & Prinz, 1990).

Therapists implement parent-focused interventions in stages, first assessing the status of the relationship between the parent and the adolescent, with particular focus on the attachment aspects of the relationship (developmentally appropriate for adolescent–parent relations, of course). Failure to maintain relatedness in the parent–adolescent relationship creates significant risk for a variety of negative developmental outcomes (Allen, Hauser & Borman-Spurrell, 1996; Greenberg, Speltz & DeKlyen, 1993). A teen's achieving autonomy while maintaining a positive relationship with parents is widely recognized as a fundamental task of the adolescent and parents (Baumrind, 1991; Steinberg, 1990). It is important to remember that adolescents continue to seek out their parents for support and guidance (Greenberg, Speltz & DeKlyen, 1993), and although the nature of their parents' influence is different from what it was in childhood, their parents continue to have considerable influence over teenagers in many areas (Hill, 1980). MDFT creates roadmaps for therapists who wish to work with adolescents and their families in more developmentally informed and developmentally on-target ways (Liddle et al., 2000).

Parenting Relationship Interventions

The history of adolescent psychology has been dominated by the theoretically derived belief that separation or individuation constitutes the central task of adolescence (e.g., G.S. Hall, Freud, Blos, Erickson). Modern-day developmental research challenges this opinion. Empirical evidence demonstrates, for example, that positive parent–child relationships foster and predict healthy adolescent development (Hauser et al., 1985; Hill, 1980; Montemayor, 1983, 1986) and, furthermore, that families serve as a primary context of adolescent development (Grotevant & Cooper, 1983; Hauser et al., 1984).

Research in this area also relates directly to MDFT's target group of at-risk teenagers. Emotional support from one's family has been found to have a protective or buffering effect against substance abuse (Burke & Weir, 1978; Greenberg, Siegel & Leitch, 1983; Larson, 1983). Supporting these data, Wills and Vaughn (1989) found that under circumstances in which there is a high level of substance abuse in the peer network, family but not peer support had protective effects. Wills (1990) concluded:

> Many parents believe that they are powerless in the face of peer pressures toward adolescent deviance. To the contrary, my findings indicate that parents, through the support they provide to teens, can have considerable favorable influence … [and] parents protect their teens by being interested in and available to talk about problems (p. 91).

Outmoded and inaccurate concepts have been replaced by the idea of parent–child interdependence as the optimal developmental condition (Steinberg, 1999).

When these relationships falter or when they remain poor over time, an adolescent's psychosocial growth deviates (Baumrind & Moselle, 1985; Shedler & Block, 1990; Kellam et al., 1983; Newcomb & Bentler, 1988). Research indicates that, unlike the families of adult addicts, which are typically characterized by a disengaged family structure (Stanton & Todd, 1982), families of drug-abusing adolescents are more likely to be disengaged but still engaging in hostile conflict (Liddle & Dakof, 1995; Volk et al., 1989). When relations are strained or have been badly damaged, attachment bonds must be shored up or rebuilt before families can consider behavior changes. Such reconnection processes can be identified (Schmidt, Liddle & Dakof, 1996), and particular therapist techniques are related to these relationship shifts (G.S. Diamond & Liddle, 1996).

Given the degree of disengagement and lack of cohesion in the families of adolescent drug users, interventions that rely primarily on parental hierarchy and power (organization) can further alienate an already estranged teenager. MDFT is careful not to replicate the excesses of approaches that overemphasize parental control functions (e.g., Madanes, 1981; Haley, 1997). Rather, MDFT fosters evolution of a new developmentally appropriate relationship between parent and adolescent. Creating cohesion between adolescents and parents involves the negotiation of new modes of interdependence (Silverberg & Steinberg, 1987; Steinberg, 1999)—a relationship definition that meshes with the developmental needs of teenagers.

Key Concept:

Parenting relationship interventions are special methods used to redirect the derailed developmental tasks of the parent and the adolescent and to increase the emotional connection between them.

Parenting relationship interventions (PRIs) support parental reconnection and are designed to put back into place the derailed developmental tasks of both parents and adolescents. At the heart of these interventions are the renegotiation and recalibration of the parent–adolescent relationship in a way that enables the adolescent to achieve increased autonomy within a context of continued but altered connectedness or relatedness (Allen et al., 1994; Grotevant & Cooper, 1983). These processes are designed to decrease the emotional distance between parents and adolescents.

Although some parents in the CYT studies function more on the overinvolved side of parenting and have difficulty granting autonomy, research indicates that with midrange and severe drug abuse and conduct disorder samples, disengagement is the norm (Liddle & Hogue, 2001; Schmidt, Liddle & Dakof, 1996; Dadds & McHugh, 1992; Patterson & Stouthamer-Loeber, 1984; Volk et al., 1989). PRIs lessen the emotional distance between the parents and their adolescent (Liddle et al., 1998). A clinician's attempts to change or even primarily focus on parenting behavior are often met with reluctance or resistance (Griest & Forehand, 1982; Patterson & Chamberlain, 1994). MDFT works to increase parents' motivation to consider a new kind of relationship with, and parenting strategies for, their adolescent. In part, this is done by focusing on and amplifying the urgent circumstances of and need to take action with the teenager (Haley, 1976). This can be straightforward in situations of crisis or when extrafamilial systems such as juvenile justice are involved. When parents are more emotionally distant, rejecting, or abdicating, the task of creating urgency to act can be enormously difficult. The following excerpt illustrates a therapist's (T's) use of an adolescent's recent suicide attempt to create urgency in the mother (M). He encourages the mother to strike a balance between appropriate limit setting and communication of her love for her son.

T: *See, this is where the real work starts now. You've been around the block with B. Come on, he's been in an inpatient…*

M: *Well, I said that to him when I found out he was smoking pot; and I said to him, "Why are you doing this?" You know?*

T: *Uh huh.*

M: *My sister committed suicide. My son told me she was his favorite aunt. So I said, "Then why are you doing this?" This was the way she started. She started with pot. She didn't think she'd wind up killing herself. You know, and the same thing when I found out he was selling pot.*

T: *And what, he runs away from that conversation, doesn't he?*

M: *Yeah.*

T: *He doesn't hear. And that's why, when you have that conversation, this is the kind of conversation you got to have over and over with him. You gotta hold him still. He's gotta hear it. I don't want you just to talk about things that are issues of control.*

M: *I always felt like a warden.*

T: *And now?*

M: *And not a mother.*

T: *That's why, together, we're gonna shape this conversation that you're going to have with him.*

M: *I do get frustrated.*

T: *Okay, all right, and I know it's frustrating. And I know you love him. And you want to protect him right now. We gotta talk to him. You gotta keep going down that path. You gotta make sure that you balance that conversation. I want the majority of it to be, "Hey, I'm concerned. Yes, you've heard it before. I'm concerned about what you're doing. You're my son. Why are you in the streets? I give you a place to stay. The food's here. I'm just trying to make sure you're okay. I want to know what's happening in your life. I don't want to lose you. I almost lost you. How come you're not talking to me?" That's where we've got to go, and that's how you've got to talk to him.*

Through a process called a "history of 10,000 defeats," parents appear to have given up or, in some cases, actively abdicated their parental responsibility for day-to-day influence attempts (Patterson, Reid & Dishion, 1992). These parents also withdraw from the relationship with their teenager. One study (G.S. Diamond & Liddle, 1996) indicates that stopping the slide of this emotional withdrawal is important to the creation of therapeutic in-session interactions between parents and teenagers. PRIs aim first to affect the affective aspects of parenting. The goal is to increase parents' emotional commitment and gradually their day-to-day involvement with their teenager (Liddle et al., 1998). Success enhances readiness to change one's parenting beliefs and parenting practices, even with adolescents who have abused drugs and are involved in delinquent activities (G.S. Diamond & Liddle, 1996; Schmidt, Liddle & Dakof, 1996).

The following excerpt provides an excellent example of a mother's (M's) ambivalent feelings toward her adolescent (W). The therapist (T) highlights the parent's expression of love and commitment, and the mother shares her hopes that her son will have a better life than she had.

T: *Let me ask you, Ms. M., about when W. was younger. Things were going more smoothly, and like all parents you had things that you hoped for him, and still do, and worries that you had for him. Could you talk a little about that?*

M: *My hope for him is for him to finish school. I can give up right now like so many others have. I'm not going to do that. I'm about ready to say it. A part of me is saying it, but a part of me is saying, "Hang in there." I'd say 10 or 20 years from now, he might hate me for it, or he might like me for it, I don't know.*

T: *You love him.*

M: *I love him. I want to see him make something of himself. You know, with him being black—I don't want him to grow up, get older, and can't get a job, because he was supposed to get an education and didn't. There are a lot of males who go out and hurt, and rob, and steal, and they blame it on the system. Now is the time—the education is out there, grab it. And half of them, to be honest, don't have the sense to go get it. And when they can't get a job, they want to blame it on [someone of] another nationality. I don't want my son to go through that.*

Parenting Styles and Practices Interventions

Sometimes a research-based parental self-help book, such as Steinberg & Levine's (1994) *You and Your Adolescent*, is used in treatment as a reference point for parents struggling to understand their teenager and to change their parenting.

Considerable evidence underscores the link between parents' psychological functioning and their perceived and actual parental efficacy (Dadds, Schwartz & Sanders, 1987; Wahler & Dumas, 1989). Core themes of parenting are frequently related to generic issues of family life, which are manifested in a family's idiosyncratic "big questions" (Liddle, 1985) represented by the parents' beliefs about what families are and what each member expects from his or her intimates. What does it mean to be a parent, a father, or a mother in this family? What do various family members think about these roles in the family?

There are certain content themes that are frequently stressed in subsystem work with parents. These fall into three broad categories: parental monitoring and limit setting, parenting skills, and methods and content of communication with adolescents.

The therapist asks how much parents know about issues such as the teenager's out-of-school activities, friends, in-school activities, and school performance. The therapist assesses the parents' ability to set appropriate, firm, and consistent limits and supports increased competence in these areas.

The therapist assesses and discusses with parents communication, listening and responding, involving the adolescent in decision making, understanding which issues to take on and which to let go, demonstrating a sincere interest in the teenager, spending time with the teenager, showing respect for the teenager, and making useful bridges with institutions outside the family.

The therapist helps parents define what is important for them to communicate to their son or daughter. For example, what are parents trying to teach their teenagers about life, about being men or women, about life on the streets, about being an African-American in this society, about the role of school or work in their lives?

In helping parents better respond to their teenager after being hurt and angered by the adolescent's behavior, therapists can use several methods. Reformulating cognitive attributions, rehearsing behaviors, and working for increased acceptance of one another through emotional expression and clarification, for example, are seen as complementary techniques.

Interventions With Other Family Members

Individuals with key roles in the adolescent's life are invited to participate in family sessions, and individual sessions are held with these people as well. Cooperation of other family members is gained by their participation in treatment on an as-needed (i.e., therapist-defined) basis. Cooperation is achieved by defining and highlighting the current serious circumstances of the youth (e.g., problems in school, conflict at home, arrest, juvenile court problems). Siblings, family members not presently living in the home, and extended family members are included in assessment, case formulation, and interventions.

In the following example, Mark's grandmother (D) and grandfather (J) have been included in an in-home family session. They are part of the household in which Mark lives and are seen as vital to fostering his adaptive socialization. The therapist (T) and Mark's mother (M) and father (F) explain the current situation, such a crisis that, if Mark gets in trouble one more time, he will be put in detention for 3 years. The therapist then lets the grandparents know how important they are to Mark's healthy development and encourages the family to come up with appropriate household chores during the coming week.

T: *Thank you all so much for being here tonight. We wanted the whole family here because it's very important. Mark is in a crisis and we're all very worried about him. As his father just said tonight, it's very hard because he's at Level Six. Why is he at Level Six?*

M: *Level Six is where they can lock him up.*

T: *So it's very serious. Bill* [a therapist's helper] *and I are therapists in a program that Mark is attending to try to help him with anger management and all the other problems he has. So the reason I wanted you all here is because you live with him.*

M: *He's 14, but on the street he acts like he's older. In other ways he's 14 but acts like a 2-year-old. He can't speak for himself and express what he wants.*

T: [to Mark's grandmother] *I think that you do too much for him. Because you love him. Now he really needs to start to do things for himself. So I would like for you to rest and for him to work. Is that possible? Is it difficult for you?*

D: *Yes, it's hard.*

J: *But for his own good, let him do it.*

T: *Mark tells me, "Oh, my grandmother loves me, she does everything for me."*

F: *She does everything for her* [referring to Mark's mother], *too.*

T: *Okay, so we'd like to start to think about some chores around the house that Mark should do that are appropriate for a 14-year-old.*

F: [to Mark] *You've gotta listen.*

Mark: *I'm listening!*

T: *Jobs.*

F: *For example, the garbage.*

M: *Homework assignments.*

D: *I was getting the clothes out of the dryer, and I mentioned that my hand was hurting. He came and finished taking all the clothes out and brought them inside.*

M: [pats Mark on the knee] *That's it.*

F: *One time, he asked his grandfather for a dollar. He gave it to a homeless person.*

T: *Some time before we see Mark again, would you and Mark work out some kind of thing that you want him to do every week, a regular thing that you will stop doing? Maybe something that he does each day and then maybe something that he does once a week. So, Mark, will you get with your grandmother and figure that out, what you will do to help take some of the work from her?* [Mark nods]

T: *So, thank you so much. Because you live in this house, everybody has to help him grow up and be responsible. He can't express himself, and when he can't express himself, he gets angry. It bottles up inside him and he explodes. So, we all need to help him learn how to express himself.*

In MDFT, therapists emphasize the need for others, particularly prosocial adults, to join forces with the treatment program to help the adolescent.

The Family Interaction Module

Goal

Create a developmentally facilitative family environment.

Rationales

- The family environment, manifested in repeating and consistent family interactions, including parent–adolescent interactions, is a critically important domain of development during adolescence.
- Basic and clinical research has clarified the particular kinds of family transactional patterns that are conducive or harmful to adolescent development.
- Family transactional patterns, as a representation of current family relationships, offer an important and accessible context to block or diminish risk factors and processes and promote prosocial adaptive developmental processes.

Procedures

- Individual meetings focus on the content for family sessions that might change family interactions.
- Techniques are planned using storyboards.
- Enactment is the primary method for changing family interaction.
- Enactment is a technique, but it also illustrates a way of thinking about change (enactment is an aspect of the change process).
- Like the other aspects of the approach, the family interaction module is broken down into parts that are organized sequentially. One way that this organization occurs is through the orchestration of a series of meetings with individuals (family members and extrafamilial others) before as well as after enactment-focused meetings.
- Therapist behavior is reminiscent of the "shuttle diplomacy" concept—there are meetings with parents and adolescents separately, together, and alone again in a sequence dictated by the unfolding process and the progress being made.
- Important areas or topics on which to work are determined.
- Priorities are decided; the downsides to working one area or issue over others are considered.
- The therapist works gradually, using successive approximations and "personal/interpersonal best" thinking.
- The therapist works on skills: establishes an agenda, signs on to tasks and goals, looks for openings, shifts affect, maintains focus and intensity, shapes the interaction, closes it up, and transitions out.
- The work must be overt; postenactment time should be used for processing, planning, and troubleshooting.

Various kinds of family interactions are linked to the development and maintenance of behavior problems, including drug use and abuse (Hawkins, Catalano & Miller, 1992). Transaction-focused change strategies have demonstrated success in changing targeted interactions, and these techniques have become family therapy's defining feature (Minuchin, 1974). Critically, changes in interactions within families are related to changes in targeted problem behavior, including adolescent drug use and abuse (Robbins et al., 1996; Schmidt, Liddle & Dakof, 1996; Steinberg & Levine, 1994; Mann et al., 1990; Szapocznik & Kurtines, 1989) and changes in the in-session problem behavior of drug-abusing teens and their parents (G.S. Diamond & Liddle, 1996; Schmidt, Liddle & Dakof, 1996).

Change in the parent–adolescent relationship is brought about through the classic family therapy technique of enactment (Minuchin, 1974; G.S. Diamond & Liddle, 1996, 1999). A sequence of individual and joint parent and teenager sessions is used as a form of shuttle diplomacy (G.S. Diamond & Liddle, 1999). The enactment method is stress provoking. Individual conversations help alleviate the relationship dislocation stimulated in the enactment-focused sessions.

The next case example elaborates on the idea of preparation for enactment. The preparation of both the daughter and the mother is examined, and the rules and techniques for initiating a conversation about a disturbing family theme are dictated.

Case Example: "I Want My Daughter Back"

Jim and Marina, divorced for many years, have two daughters: Sally, age 15, who resides with her mother and stepfather, and Cynthia, age 20, who lives on her own. Marina sought treatment for her younger daughter's marijuana and alcohol use, her daughter's poor grades, and their progressively distant relationship. Sally's stepfather was decidedly uninvolved in childrearing tasks. Marina was concerned with Sally's substance use and with her daughter's drifting away from her toward what Sally called her "adopted" family, her girlfriend's family. That environment permitted drinking and other freedoms counter to Marina's values.

Abandonment was a central theme in this case. It is difficult to imagine addressing the topic of emotional or physical abandonment without dealing with issues of the past. The theme of abandonment most often emerges in session through examination of the adolescent's intense feelings that come from memories of being abandoned or neglected, as well as those that accompany the parents' experience of their own behavior. The feelings are key domains of therapeutic operation.

In this case, the daughter felt abandoned by her mother, who said explicitly that she was choosing to protect her second marriage at the cost of isolating her daughter. Marina, seemingly unaware of the impact of this on her daughter, felt abandoned by her daughter as well. Sally's emotional involvement with her friend's family, although it gave Sally attention and security, was difficult for Marina to accept. In situations like this one, in which there are powerful themes, problem-solving and negotiation strategies can easily fail.

Therapist Improvisation: Shifting Domains of Operation

The key principle illustrated in the following sequences is a shift in the therapist's focus; a multidimensional model allows the clinician maximum flexibility for in-session work. At the previous session and the beginning of the current session, Marina expressed extreme pessimism about her daughter. The clinician was aware of her pessimism and was looking for productive ways to address and, if possible, counteract it. The therapist decided to challenge the mother's pessimism in a straightforward problem-solving way by trying to initiate a conversation about mother and daughter having dinner together (a rare occurrence). When the therapist assessed that this approach was not working, she shifted her focus. In the first segment, the therapist (T) was clarifying her rationale for requesting mother- (M-) and-daughter conversations in the session.

> **T:** *What's this about? Well, it's about having a relationship with your daughter. It doesn't necessarily mean it* [the contact that the therapist is trying to facilitate] *has to be as formal as a date.*
>
> **M:** [interrupts; seems frustrated] *Well, it does because she doesn't want to have anything to do with me.*
>
> **T:** *What about dinner?*
>
> **M:** *She won't have dinner with me. She will not sit down. She has not sat down and had dinner with me for 2 years.*
>
> **T:** *Would you like her to have dinner with the family?*
>
> **M:** *Sure, it's normal. Sure.*
>
> **T:** *So, what do you have to do? What are the kinds of things that go into this? Let's not assume that* [arranging for the daughter to sit down for a family dinner] *is out the window.*
>
> **M:** [discouraged] *It is out the window.*
>
> **T:** *Mmm.*
>
> **M:** *Well, I mean, after 2 years it is.*
>
> **T:** [sits forward and addresses father] *Jim* [Sally's father], *can you convince this lady that she's got more influence over this kid?*
>
> **M:** [interrupts, sounding a bit insulted] *Well, I don't have the energy to go in and scream and yell and pull her out every day. You guys make this sound like it's really easy, and it isn't.*

The therapist makes a dramatic shift and asks Sally to leave the session for a few minutes.

> **T:** [to mother] *I wanted Sally to step out because I think you're feeling ganged up on.*
>
> **M:** [interrupting] *I feel really ganged up on. You guys make it sound real easy and it's not.*
>
> **T:** *I'm here to try to make life easier for you. Do you believe that?*
>
> **M:** *Well, maybe. I don't know.*

This dialog continues for about 20 minutes. It ends when the therapist makes the following statement that reaches Marina.

> **T:** [to mother] *So why are you doing this* [coming to therapy, trying to reach out to your daughter]*? You're doing this because you love her and you're concerned about her. You've already lost your older daughter to drugs. And you don't want that for Sally. I don't want you to feel that I am ganging up on you or that Jim is ganging up on you. I will do everything I can to support you.*

Intentional and Unintentional Shifts in a Session

This segment contains several important shifts (G.S. Diamond & Liddle, 1996, 1999). First, the therapist shifts the focus of the session from the daughter (e.g., "Are you interested in having more of a relationship with your mother?") to the mother (e.g., "I think you're feeling ganged up on"), and, perhaps most important, to the therapeutic alliance between Marina and herself (e.g., "Are you mad at me right now?"). By asking Sally to temporarily leave the session, the therapist signals her respect to the mother (i.e., "I sense you are upset and I want us to deal with that").

The shift from mother–adolescent problem solving attends to Marina's experience and her individual needs. When the therapist puts herself and Sally's mother into the center of the process, another shift occurs. These moments illustrate the sincerity and credibility that have been established between the therapist and Sally's mother.

The ground rules for being attentive to and reading feedback can be made explicit and depend on lucid personal judgment under difficult conditions (Liddle, 1985). In this sequence, although the therapist has a specific agenda for the session, she appropriately adapts her style, content, and focus to the feedback. Aspects of this conversation include (1) confirming the mother's anger ("I think you're feeling ganged up on") and despair ("You are really angry and frustrated"); (2) compassion for the difficulty of her situation ("This is really hard for you"); (3) normalizing the behavior ("Anyone would find this hard"); and (4) offering new explanations ("She is not used to you reaching out to her") and restoring commitment ("You love this child"). The conversation redirects the mother's negative feelings (e.g., "My daughter doesn't care about having a relationship with me") and lack of motivation for a relationship with her mother (e.g., "This kid just does not want a mother").

Before she asks Sally to come back into the session, the therapist meets briefly with her alone. She tries to prepare Sally for subsequent work with her mother. Sally is challenged to "rise to the occasion" and to take her own desire for independence more seriously. Sally agrees to try, and the therapist and Sally go back to the session.

In the next segment, the mother's change is clear. The previous therapist–mother interaction had placed Marina in a vulnerable spot.

Sally originally sat on a couch with her mother, across from Jim. To intensify the mother–child proximity, the therapist moves Sally to the chair across from her mother.

> T: [to Sally] *I want you to turn your chair to your mom. I want her to have a chance to say these things to you directly, because I was very moved by some of what she said. Okay?* [The pace is intentionally deliberate and the tone is serious.]
>
> M: [in a sad voice] *Well, first of all, it's very hard for me to talk, because I feel so bad about all this. I feel the loss of a daughter.*

I miss you. There are things that I want to do with you. I want you to be my daughter and you don't want any part of it. That's very hurtful. [pauses] *I see mothers and daughters enjoy each other's company, and I just feel like you want nothing to do with me.* [begins to cry] *I came from a family of mothers and daughters. That's a very special thing.* [becomes upset again] *I lost one daughter* [a reference to the mother's estrangement from her older child] *and now I'm losing another.*

T: *And you don't want to lose her.*
M: [emphatically] *No.*
T: *And you don't want to have to make rules, but you don't know how to connect with Sally, you don't know what to do.*

Sally was, up to this point, not responding very much to her mother's efforts. The therapist continues to encourage her.

T: [in a soft voice to Sally] *Your mother is being particularly open right now, Sally. She's not saying this to hurt you; she's saying it because she feels so sad and she loves you so much. Help your mom know how to have a relationship with you. I don't believe for a minute that you don't miss that too, Sally.*

Sally has her head down and is crying. The therapist hands her a tissue.

T: *I think that's why you're crying right now. I don't think you want your mom hurting like that. Why is that? I think it's because you love your mom. Talk to her, Sally.* [long pause; the therapist gets up and moves next to Sally and puts her arm around the girl's shoulder] *Okay, come with me.*

Sally accompanies the therapist out of the session. Shifting gears, the therapist quickly assesses Sally's feelings about what is happening, as well as her willingness to respond more fully. They return to the session with the therapist not sure how far Sally is willing to go on this occasion.

T: *So, Sally, tell your mom what's going on.*
S: *I don't know.*
T: [challenges] *What do you think about the things she said? Sally, why are you crying right now?*
S: [to mom] *Because I don't want you to feel that way.*
M: *Well, how else can I feel?*
T: [strong, challenging] *Why don't you want your mom to? Why? Why do you care?*
S: *Because I love her.*
T: *Then, tell her you love her. Your mom needs to know you love her.*
S: *She knows.*
T: *No, she doesn't know, Sally.*
S: [to mom] *You don't know?*
M: *Well, I think you sort of love me, but I think you sort of love to be away from me. You don't want anything to do with me. Nothing.*
T: *That makes you feel unloved.*

M: *Very unloved.*
T: *That's why I'm saying—I don't think your mom really knows that. If that's how you feel, then let her know.* [Sally still averts her eyes.]

The therapist nurtures this mood and discussion. Family members often need more coaching during these early change attempts.

On this occasion, several questions might occupy the therapist:

- What will it take for the daughter to respond at the same level as the mother?
- Has enough groundwork been laid with the daughter individually? Does the daughter believe that her mother really wants to hear what she might have to say?
- To what degree should the therapist encourage the daughter to express herself (rather than involve the mother in the encouragement)?
- What are some reasonable outcomes for this sequence on this occasion? And is it not possible that asking Sally to respond in this session may be reaching too far at this time?

Questions such as these inform a clinician's judgment on a moment-to-moment basis; recalibrating one's interventions in a session is one of the most complex of all therapy skills.

Given that in individual sessions Sally had not shared ideas about what she wanted in a new relationship with her mother, the therapist concludes that this sequence has progressed as far as it could on this occasion. The mother remains emotionally available and nonblaming to Sally.

In the final sequence, the therapist works to construct a useful ending to the session.

T: *I don't think that we can have a sense of closure tonight on this topic. Marina, I have to say that I was very, very moved, as I think everybody in this room was. I know what you said was very hard. I think that you certainly deserve some support, and I'm wondering if there's anything that you need from Sally before you leave this room tonight?*
M: *I'd kind of like a hug.* [with more firmness] *I want a hug!* [Mom and daughter reach out simultaneously and embrace each other and the therapist then ends the session.]

During this session, the therapist sometimes tried too hard to engineer a breakthrough. Furthermore, the therapist, in a discussion later with her supervisor, realized that she had too many preconceptions about what the hoped-for process ought to look like. This sequence serves as a reminder that each participant in the conversation does not participate in the same way or at the same pace, nor is it important for him or her to do so.

Key Concept:

Bottom-line case outcomes are achieved by breaking the work into smaller outcomes.

Finally, this sequence presents another opportunity to remember the focus in this approach on an incremental view of change. This is the emphasis despite the fact that change can be defined as having both continuous and discontinuous elements (Liddle, 1982). The focus is on working on and framing change for family members as a series of small steps. These steps are defined by Mahrer (1988) as "good moments" of therapy (i.e., processes that are instrumental to change). As Greenberg and Pinsof (1986) have put it, outcome should be broken down into the "small o's" (small outcomes) that make up a ground-level view of the therapy process. Fixation on the final product, the "Big O" of a final outcome or a "Big Event," can create unrealistic expectations and a focus on the wrong level of detail. Paying attention to these Big O's would be like trying to hit a home run every time one was at bat.

In subsystem work, the therapist might well be working with a parent about acceptance or about understanding the connection between his or her own behavior and that of the adolescent while at the same time (i.e., the same session or the next session) talking with the adolescent about his or her own concerns (e.g., parental or peer rejection, disconnection from family or school). Thus, a therapist may block a parent's persistent request for information about the teenager's current drug use and related behaviors. At the same time, the therapist may help the parent continue to reach out to the adolescent by sharing with the teenager the effect of the drug use or problem behavior. This is not done, however, in a way that elicits blame and negative attributions from the parent.

Case Example: Building a Relationship Bridge

The following is an example of work with a mother (M) and son (R) in which the therapist (T) attempts to elicit the parent's personal meaning from statements that in the past had taken an accusatory turn.

M: *Well, I can't follow R. out in the street and keep him away from the boys who are into stealing and staying out till all hours.*

T: *I agree with you, Mrs. Williams. There are a lot of things you can't control. But that doesn't mean there aren't ways you can influence him. I can help him listen to you.*

M: *Well, I sure hope so. I must have been up most of the night on Thursday. R. went out right after dinner and wasn't back when I went to bed. I don't think he got in until 3 in the morning or so.*

T: *And I'll bet you were worried sick. What were you thinking about when you lay there awake?*

M: *I was thinking, "The police'll be by any minute to tell me R. has been shot." That's what I was thinking. I don't think I could bear losing R.*

T: *Does R. know what you went through that night?*

M: *Well, he sure knows I was angry, 'cause when he did come in I went downstairs and I guess I really went off. I was just screaming and carrying on and he kind of stood there until I finished and then we both went to bed. We haven't talked much since then.*

T: *So, R. doesn't know really what you go through when he stays out? I really think it's important for him to know. I think it would be good for him to hear that today when he comes back in. You and he have a relationship. Don't assume that it doesn't matter to him what you go through.*

The therapist must find a way to help parents tell a story about themselves and their parenting that speaks to their worries, hopes, and dreams for their child. If a mother, for example, has long been expressing caring for her son in ways he cannot take in—threatening, nagging, yelling—the therapist will want the teenager to be let in on the feelings that underlie these behaviors. This does not mean that the mother should say only "positive" things, however; it means that when she talks about her adolescent's negative attitudes and behavior, she must be helped to do it with reference to how it affects her, their relationship, and the future as she sees it. For parent and teenager, talking together will be an important means of healing their relationship and building a new connection.

The therapist prepares parents for these in-session dialogs or enactments. At this point, she has a chance to help a mother come to a new understanding of what has been going wrong in conversations with her child. Later, the therapist has an opportunity to intervene during the actual discussion to keep it on course, helping mother and son see what is not working in the way they talk to each other. The therapist and parent, for example, may talk together and agree that the parent's lecturing of her son is not working and is, in fact, pushing him away. A discussion may ensue about how she can talk to him in different ways. When she lapses into her "lecture mode" during the session, the therapist may ask the teenager, "Is she lecturing right now? Is this the kind of thing you said is turning you off? What happens when you hear her lecturing?" She asks both teenager and mother to talk about how each withdraws following one of their "talks" and gives them opportunities to have a different experience in the therapy room, as she continues to help focus and shape the conversation.

This approach is extremely flexible, because, depending on a variety of factors—receptivity, motivation, and capacity to articulate the problem, among others—the therapist can turn to either mother or son to carry the weight of the discussion. Likewise, when either mother or son shows a quite natural reluctance to persist in the discussion, through discomfort born of lack of practice, fearfulness, lack of trust in the other person or the therapy process, or a need to continue to attack or blame each other, the therapist can meet alone with that individual to try to remove impediments to dialog. The following is a sample from such a discussion:

T: *R., what's going on in there? You and I agreed that it was important for you to tell your mom how angry you were when she told you off in front of your friends. Don't bail out on me here. I can help her hear you, but you need to do your part, too.*
R: *I know I said that, but she's not gonna listen to me. She never does.*
T: *It sounds as if you're feeling really hopeless about what we can do together to make things change. What do you think will happen if we bring this stuff up today?*
R: *Well, she'll say all the right things when we're here, and then we'll go home and everything will be the same.*
T: *R., if that's so, I also want us to say that to her—that you don't really trust her yet to follow through. I want to help you with this, R., but I can't do it without you. Can we agree to go back in there and at least try?*

The following is a sample discussion of the same type with R.'s mother:

T: *Mrs. Williams, when we were in there, it seemed as if you stopped talking when R. didn't respond right away.*
M: *Well, I just can't stand that attitude. It completely turns me off.*
T: *Say a little more about the attitude.*
M: *It seems like I'm doing all the work, and all I get in return is Mr. Stoneface.*
T: *So what you mean by "attitude" is that he doesn't appreciate what you're doing, and when you sense that, it makes you really angry.*
M: *Yup, that's what I'm saying. With all we do for him, and then he just sits there.*
T: *Then, underneath the anger, you would say you're feeling hurt. You feel really uncared about when he doesn't respond to you.*
M: *You've got it.*
T: *And when you don't feel cared about, it makes it hard for you to reach out in the way we've been talking about. So, let's talk a little more about how you withdraw rather than letting him know what's going on with you.*
M: *Yeah, I know what you're saying. You're saying I've got to hang in there, because when I don't say anything, then we just go to our corners and nothing changes. I know I've got to keep on trying.*
T: *Right. Now you've got it.*

Facilitation of an in-session dialog between an adolescent and his parents sets the stage for further dialogs outside sessions. In the following example, the therapist uses the adolescent's willingness to share the difficulty he has in staying "on the good side" and resisting drugs; the therapist's supervisor also calls in to assist with the facilitation. This session includes the therapist (T), the adolescent Willie (W), his mother (M), and her partner Matthew.

T: *This young man wants to make it, but he's always walking a fine line, right?*
M: *Right.*

T: *One part of him wants the good, but there is another side, something else pulling at him, right?*

W: *Right, that other side wants something else.*

T: *But, what is it the other part wants? Messing up?*

W: *Bad things.*

T: *Bad things?*

W: *I'm trying to move to the good side 'cause, you know, I close my eyes and I think about what happens when the world ends. I'm still in the bad side, but I'm trying to go a little to the good side, so when I die I can go to heaven. You know, I don't want to be burning in hell for the rest of my life.*

T: *It's a tragedy happening in our society that kids say, "Maybe I'll die, so who cares?" I am very glad that you appreciate what life can bring you. But you're pulled on two sides.* [to mother and Matthew] *I think it's important for all of us to understand more of what he's going through in his heart and in his mind. Let me show you today.* [pulls a chair between therapist and Matthew] *Bring the chair. I will ask you to tighten your hands* [Mom and Matthew join hands] *and then put this chair on this side, your chair on your side, your mother's side.* [Willie moves his chair in between the therapist and his mother] *And then I would like you to pull toward him, and I will represent the bad side for a moment, the bad kids in the street. And we will see what happens. Okay, go when I say "three." Let's see who wins.* [Mom and Willie pull from one side, therapist from the other in the figurative tug of war in which the forces of the family and forces of the street are represented] *Who won?*

M: *I did.*

W: *I don't know.*

T: *They did.* [points to Mom and Matthew]

W: *How?*

T: *They pulled harder.*

W: *Y'all wanna try again?*

Matthew: *No. That was the idea, Willie, for us to win. The idea was for the good side to win.*

T: *Do you want to try again? He needs to experience that again.*

M: [to Matthew] *Why don't you sit on this side?* [they switch seats]

T: *Let's go. Okay, you ask him to help you more, and he's helping you. That's good. Okay, one, two, three.* [Mom and Matthew win again. Willie comments that the tug of war was so strong that his hand hurt in the process.]

W: *Ouch, your nails!*

Matthew: *Whatever it takes.*

M: [laughing] *Whatever it takes.*

T: *Congratulations.* [therapist shakes hands with Willie's Mom and Matthew] *You are very strong. This shows me one more time that when families pull together very strongly, they have a lot of power.*

M: *Right.*

T: *And I'm sure that, with your strength, you will be able to pull him in the right direction. But we need to remember that there's this other half holding strong. Right? So, Willie, your mother and*

Matthew will make sure to always pull you to the good side—for a good reason.

[The supervisor calls and gives the therapist a suggestion.]

Supervisor: *I think this is good. Just a small suggestion to finish this off and get everything out of it that you can. This family needs to understand what this other side (the bad side) is. They understood it physically through the exercise, but they could also understand it more fully if Willie tells them about the pull of the bad side. In whatever ways he's comfortable doing it, he needs to tell them about the other side, about the pull to do bad things. He could do this for a couple of minutes. And then, he could talk to them about it more during the week. This could go a great distance toward helping them prevent any slips or relapses. So, they have things on the right track, and you're saying to them that part of the medicine to get things straightened out is this boy revealing to them and sharing with them what his struggle is about. You'll have him explain what's behind the physical struggle that you created. Okay? Very good.*

T: *Willie.*

W: *Yes, sir.*

T: *Before we leave, we still have something very important to do. Can you say one word that represents the bad side, the side that pulls you?*

W: *What do you mean?*

T: *You know, the tough kids, the kids who don't care for life, tell me one word that represent those guys.*

W: *The bad side?*

T: *Yeah, one word.*

W: *Weed.*

T: *Weed?*

W: *Right. It's no good. I gonna cut down on that weed, man. It's not doing nothing to me but just hurting me, killing me little by little, killing my family little by little.*

T: [shakes Willie's hand] *Beautiful. I am glad to hear you talking this way. Hopefully, you will maintain that.* [to Mom and Matthew] *I would like this dialog to continue—he will be able to talk more with you. Ask him more questions about this other side, this side that he says he wants to leave behind. In your house, during the week, can this conversation continue? It will be about the other side, the bad side, from Willie's point of view. I think you need to understand his struggle, understand those forces.*

M: *Right, to understand what the pull is about.*

T: *Yeah, what the pull is, and in more depth. And I think he will feel very good inside if he can talk about it with you. So then he doesn't need to feel all alone with that, but he will feel supported by the two of you. I know that you do support him, but he needs to know that in a more direct way. He will then be more like a 15-year-old. Not like a young child, but like a young man. So he needs to put that in words, not to behave like a comedian or an actor. But by talking with the two of you about these issues, I think that that will help a lot. That's a big part of this medicine. Okay?*

M: *Yes. Okay.*

Key Concept:

A key therapist task during sessions is shaping and guiding the family members' discussions to keep them productive, rather than negative and blaming.

Individual sessions are used for more than providing support to deal with the stress invoked in joint sessions, however. There are prospective and retrospective aspects to the individual meetings. Individual sessions with the parents and adolescent are important opportunities and arenas of work, in and of themselves (i.e., the holon–whole-part principle). They also serve linking functions relative to whole-family sessions. For in-session discussions between them to be useful, parents and adolescents must first be able to communicate without excessive blame, defensiveness, or recrimination. Interventions with parents and adolescents aim to reduce negativity—a basic objective in all family therapy (Robbins et al., 1996)—and to position each person for more constructive discussion and negotiation. The renegotiation of the parent–adolescent relationship during this stage of the family life cycle is delicate; it is accomplished in subtle ways; and it is important to developmental outcomes (Fuligni & Eccles, 1993; Pardeck & Pardeck, 1990; Ferrari & Olivette, 1993). The therapist sponsors these conversations, shaping and guiding the discussion to keep it productively focused (G.S. Diamond & Liddle, 1996).

When parents and their adolescent come together in these ways, a teenager's competence in expressing needs and addressing responsibilities is elicited and enhanced. This process and these behaviors encourage and motivate the parents and provide an antidote to parental withdrawal and abdication.

These new interactional patterns are seen in the context of other kinds (e.g., first stage) of changes (emotional accessibility or empathy toward other family members, new concrete options [new school, vocational training, job] outside the family). Their interactional patterns reveal the quality of their family relationships. Finding a successful way to focus on and alter these interactions positively is fundamental to influencing a reduction in adolescents' symptoms and a gain in their prosocial behavior.

An example of such an interactional pattern follows. The therapist has prepared the adolescent in a previous individual session and facilitates a difficult dialog about the sadness and embarrassment both mother and daughter feel. This session includes the therapist (T), the adolescent (F), and her mother (M).

T: *I know it hurts, but could you try to hold back the tears? Francisca, try to answer your mom when she finishes telling you how she felt. I want you to tell her how you feel and what that was like for you.*

F: *I don't understand.*

T: *Okay, she's gonna talk to you about how it felt for her, what you did, and then I want you to be able to answer what she is saying and how it was for you.*

M: *How do you think I felt when they threw us out of the house, the green and yellow one? Do you remember? Why did they throw me out? Because you guys were destroying the apartment there. There were gangs, and they were stealing. I felt ashamed, like the worst of the people that lived in those apartments, knowing that we were once one of the best families living in those apartments. You are dragging the whole family down; we moved into this house and it was the same thing. You brought your friends in, you and your sister. You stole from the owner of the house. It was only after you and your sister went to detention that I was able to repair the house; it was full of holes. You have stolen from me, and your friends have insulted me here in my own house. After your drinking and smoking in my own house, I felt like the lowest person in the world, like I was not worth anything. I have no reason to feel like that because I have been in this country 19 years and I have raised five kids. They are not perfect, but they have been good kids, and you know that they respected me and they know how to value me as a mother. I give you guys everything. I dress in clothes that others give me so that I can give you guys the best, and I want you to understand how I feel. There is no reason why I should be going through this. I feel ashamed, Francisca. You and your sister are not the same as you were before this all started. This is not who you are. You are not the Francisca that I raised or the Francisca that I gave birth to.*

T: *So, Francisca, you had something to say about your friends and how that is. But first talk to your mom about what she just said. She told you a lot. She told you a lot about her embarrassment, her humiliation.*

F: *Yes.*

T: *She is telling you is that she has tried to have a good life here, and that what has happened with you and your sister has caused shame. What do you think about that?*

M: *You don't feel bad about me having to go through all this. You have nothing to say?*

T: *Mrs. Torres, could you ask her just what it was like for her? You've told her what it was like for you.*

M: *How do you feel about everything that has happened? The months that you were locked up in an environment that you don't belong in, separated from your family, your mother. Are you embarrassed to speak?*

T: *Francisca, we made a deal, remember? This is the time we have available. This is about helping you grow up. And it's about helping you talk to your mom and tell her how you feel and what it was like for you. That's part of having a new kind of relationship with her. Francisca, this will allow you to have some things your way, not everything your way, but have her understand what you are going through. So, this is, I think, a big thing. She's sincerely asking you to tell her how was it for you. How was that time, how is it* *now away from your twin on your birthday? How is that? Will you talk to us about that some?*

F: [shakes her head no]

T: *Why is that? Well, if you can't talk about it, then will you leave us for a little while? You can go in your room for a while. Here is what I want you to do. Go in there and get ready, prepare yourself to come back in and tell your mother how all this has been for you. Can you do that?*

F: [nods her head yes]

T: *How long do you think you need, about how many minutes? Five minutes, is that enough?*

F: [nods her head yes]

T: *So I'll knock on your door in 5 minutes, and you'll be preparing what you need to say to explain how this has been for you.*

F: *Okay, I'm going to the back.*

[Francisca returns]

T: *Do you understand that this is very serious? This is your chance to talk about how you feel. You understand, okay, it's not a joke or anything.*

F: *I'm not laughing.*

T: *I know, I know you're not. I'm trying to say, this isn't just for your mom, this is for you, too. So tell her what it was like for you going to DJJ* [juvenile detention].

M: *Look at me.*

F: *I don't know what to say.*

M: *Say it in English, and the therapist will tell me. Go ahead, look at me and pretend that nobody is here, only you and me.*

F: *The words don't come out.*

M: *And how do you talk to me when we are together in the room, how do you tell me if you want a pair of pants or to watch the TV? Pretend that the therapist is not here, then go ahead.*

T: *So what was DJJ like, Francisca?*

F: *A terrible place, because people tell you what to do. Of course, your mom tells you what to do, but these are people you don't know. You can't eat when you want to eat, the food is nasty, you can't take a shower when you want to.*

T: *What were the guards like?*

F: *The guards, most of them were nice; the rest were mean.*

T: *What were the other children like there?*

F: *They're straight, because some of them are nice, because they talk to you.*

T: *And you lived in a cell, and where did you sleep?*

F: *When I first got there it was on the floor on a mattress, and then after I was sleeping on that thing.*

M: *In the block?*

T: *Tell her how many people were in the room where you slept.*

F: *There's two.*

T: *Tell her in Spanish.*

F: *There were two people sleeping in each cell, but there are a lot of people in the unit.*

T: *And what time did you get up? What time did they wake you up in the morning?*

F: *5 a.m.*

T: *Tell her in Spanish.*

F: *At 5 a.m., she knows, I already told her on the phone.*

T: *Tell her again, now.*

F: *5 a.m.*

T: *And then what did you do? Tell her what you did all day.*

F: *At 5 a.m., you have to get up, brush your teeth, make your bed, get dressed, and stay there for about an hour. Like about 6 or 7 a.m., you go to the cafeteria to have breakfast; then, you walk back to the cell. They put you in the cell, and then you sleep. If there is school at 8 or 9 a.m. you go, and then at noon we go eat. Then we go back to the cell.*

M: *What about at night?*

F: *It depends. If the girls are behaving, we get to go outside after we shower. We watch TV, we eat dinner, and then we go back to the cell. If we misbehave, we have to stay in the cell the whole time.*

T: *What was it like when you had to go to court? What was it like when they brought you up to court?*

F: *You know how many times I've gone to court?*

T: *Well, when they brought you from DJJ, what was that like?*

F: *But that's the thing, I went a bunch of times.*

T: *Okay, so what did it feel like? Did they put you in the leg shackles to bring you up? Were you cuffed?*

F: *When I was coming to court, yeah.*

T: *You were cuffed. What was that like? Tell your mom what it felt like to be in those shackles.*

F: *Well...*

M: *How did you feel?*

T: *Was it good, was it a good thing? Tell her what it was like.*

F: *No, I felt very bad because they treated me like I was a criminal, like I was a dog.*

T: *So, do you think you felt really bad, Francisca? I would have, I mean that must have been horrible, right? Right, so can you, I mean, do you relate a little bit maybe to how your mom felt with it all going on and the eviction and everything, getting up out of the house and everything? Does that make you think a little about how she might have felt? She wasn't in shackles, but in a way she was. Do you understand?*

F: *Yeah, I do.*

T: *When she was sad, how do you think what she felt is like what you felt?*

F: *'Cause she was sad.*

T: *Tell her.*

F: *It was the same. When I was sad, you were sad. You would cry and I would cry, too.*

T: *That's right. Tell me a little bit about this. It's a big thing coming up for you with Julia in detention so long, but at least she got moved. Tell your mom, tell your mom we talked about that some, about how it is for you with Julia gone. Talk about that a little bit more. How does it feel to have her away?*

F: *It feels bad.*

T: *Tell her in Spanish. Tell your mom; turn to her.*

F: *It feels very bad. I'm going to start crying.*
T: *That's okay. Can you comfort her, Mrs. Torres? You have all been through a lot and what you have is each other. She needs her mother very much, and you need your daughter very much.*
M: *It's okay, Francisca, please stop crying.*
T: *Mrs. Torres, maybe she needs to cry, to cry a lot. I think Francisca has a lot of tears and pain built up in her from all she has been through. She needs you so much to hold her and wipe away her tears, because she is still a child.*

In this interaction sequence orchestrated by the therapist, we see the therapist helping the mother tell a story about herself and her parenting—a story about her hopes, humiliations, and past events—then helping the daughter express herself and the hurt and humiliation she, too, has experienced. This segment of the transcript illustrates enactment, the beginning of a mother and daughter reconnecting emotionally following extensive individual work with both. The Family Interaction Module focuses on a "new conversation." These are interactions, facilitated and shaped by the therapist, in which members of a family begin to hear and experience each other in new ways. These are examples of one way to work one of the pathways of change, as well as the small steps that make for new emotional connections and family relationships.

Extrafamilial Module

Goals

- Create openings for new kinds of skillful transactions with relevant extrafamilial persons and institutions
- Eliminate barriers to treatment
- Coordinate social systems with an influence on the adolescent's circumstances.

Rationales

- Adolescents and families exist in multiple ecologies, and interactions with people and social institutions outside the family can be either helpful or unhelpful to development and problem solving.
- Changing important developmental domains such as the adolescent's life skills and family transactional patterns may be necessary, but not sufficient, to change the contextually embedded and influenced lifestyle symptoms of drug abuse and delinquency.
- Case management and therapy are integrated in the MDFT treatment program. Case management is therapeutic, and "therapy" addresses practical, everyday concerns and life problems.

Procedures

- Assess multisystemically.
- Search for concrete, prosocial, development-enhancing alternatives.
- Identify advocates for the adolescent and/or parent.
- Emphasize neighborhood or community influences.
- Emphasize connections with school or work settings.
- Emphasize mobilization of support systems for parents.
- Work intensively and with a practical outcome focus.
- Connect extrafamilial work to intrafamilial and intrapersonal work.
- Use extrafamilial work as leverage for familial or intrapersonal work.
- Schedule school, work and, if applicable, juvenile justice meetings during the first phase.

This family-based intervention does not assume that changing family interaction patterns alone is sufficient to influence the symptoms of problem behavior of youth. (This was an assumption of classic family therapy.) The MDFT approach works with individuals in ways that individual therapists find familiar. In addition, however, this individual work prepares the individual family members for interactions with one another in future sessions. Working with family members together or alone is not sufficient to influence all problem behaviors. Development is influenced for better or worse by many extrafamilial and social forces, and these aspects of the child's ecology are also assessed and targeted as necessary for intervention.

Key Concept:

Extrafamilial system members are cultivated as friends of the family. Each party is motivated and assisted to work in the best interest of the adolescent.

The MDFT therapist works to develop the frequently hidden natural resources in the family and in the multiple systems in the adolescent's life. This broadened focus requires that MDFT be conceptualized as a community-based modality. Some of the systems with which teenagers and families are involved overlap and affect one another. The school, the juvenile justice system, and the teenager's peer group are primary focuses of assessment and intervention. The therapist helps the family contact school officials, including teachers, school counselors, and administrators. It is important to maintain respect for the roles and functions of each of these systems with regard to the teen. People who are extrafamilial sources of influence, all of whom care about and are working in the best interest of the adolescent, should be cultivated as friends of the family. Using an element of coercion in a treatment program is not a negative thing, if the coercion is coordinated with therapeutic dimensions. Although the MDFT model has never operated within a formal juvenile drug court context, the treatment program is set up relative to the family or juvenile (delinquency) court in a way that has juvenile drug court features. For example, probation officers are called in regularly to bolster treatment by providing information and having input in the teenager's formulations about his or her life.

Interventions in Relation to the Peer Network: The Ecomap Method

The Ecomap (a visual representation of a social world and its influences) method involves the therapist's guiding the teen and the family in drawing a map of the adolescent's social network. Multiple maps may be drawn—one of the neighborhood, one of the school and the teen's peer network there, and one of the family and its extended family and/or system of support. The objective is to make the forces of social influence concrete in the adolescent's and family's lives. A multiple systems therapy must understand the multiple sources of influence. An Ecomap offers the same idea in the sense that it is the contextual *lay of the land* that the therapist seeks to understand.

The following vignette illustrates use of the Ecomap in a session to get information about core topics in an adolescent's world. It is a prompting device to help the teen talk about some of the salient features of his or her social world. This segment illustrates the teen's quest to develop a new perspective on, and an ability to have new kinds of conversations about, his or her world. This method facilitated the teen's communication of his interests and goals to his parents in a way that was new for him and new for his parents as well.

Present are the therapist (T); the adolescent, Mark; his mother (M); and father (F). In this segment, the Ecomap enables Mark to introduce his peer world to his parents. And, in an event not uncommon during sessions that are held in the home, two of the teen's friends come to the house to visit during the session. The spontaneous therapeutic use of this unplanned event in therapy is illustrated in the second portion of the session.

> [Mark and his father are sitting on a sofa in the family's living room.]
>
> T: *We've talked about this before and I would like to try something tonight. Mark, I would like you to get a pencil and paper and draw for your dad what you call "the neighborhood." Remember we talked about this before?*
>
> Mark: [nods yes, gets the paper and pencil, and begins to draw]
>
> T: *You have to tell her* [Mark's mother] *how you feel. That's how she gets to know what's going on with you. Right now, you're not talking to anybody. Where does that leave you? That leaves you climbing*

out the bathroom window, going on a trip to run away to who knows where. You know, your dad's right; at some point, you're gonna run out of places to go. If you could start to tell people in your family how you feel, they could start to do something to accommodate you. That means they can do something to help you get what you want. I think that when you do stuff that gets you in trouble, it's about you trying to get what you want. Am I right?

Mark: [nods]

T: *Do you have trouble getting what you want?*

Mark: [nods]

T: *Uh-huh. But what happens? Do you think your parents know what you want?* [she motions for the note pad he has been drawing the Ecomap on and takes it] *Do they know what you want?*

Mark: *I told them I don't want anything.*

T: *Mm hmmm, but what—you want something...*

Mark: *No, I don't.*

T: *I think you do. You want to see your girlfriend. You want to go out in the neighborhood that you're drawing very carefully. You do want to be able to go out to some of these places, right?*

Mark: [nods]

T: *Okay, so that's wanting something. You want to see your girlfriend? That's wanting something. You want to go fishing sometime with your dad, is that right?*

Mark: [nods]

T: *Okay, those are all things that you want to do. When people say that you want something, it's not just things.*

M: *Material things.*

T: *It's not just material things; those are probably the least important of anything in life. It's these other things—relationships, people, family. Our job here, and I think I'm failing in this so far, is to help you figure out how to tell people what you want, to tell them what's going on inside of you.*

[pause]

T: *Let's try it this way.* [she hands Mark the note pad with the Ecomap he was drawing] *How close are you to being done with the map? Show me where your house is.*

Mark: [points to the paper]

T: *Okay, is the neighborhood gonna fit on this page?*

Mark: *Yeah, it started to.*

T: *Okay, explain the map to your mom and dad. Okay, is it ready now?*

Mark: [nods]

T: *Where do you want to be able to go in this neighborhood?*

Mark: [pointing at the Ecomap] *Okay, I want to go to Juan's house, Billy's house, and Manny's house. Those are the only three houses I want to go to in this neighborhood.* [talking to his mother and pointing at the map] *You already know where Billy is, you know where Manny is, right? He's the one with the bike.*

M: *That's their house on the corner?*

F: *Can I ask you a question?*

Mark: *What?*

F: *What were you doing all the way on East 167th?*

Mark: *I was catching a bus to go to my girlfriend's house.*

T: *Okay, so you were leaving the neighborhood at that point. Okay, they know these people?*

M: [pointing at the map] *Well, I know this one. I'm not sure who this one is.*

Mark: *You remember, the one with the bike.*

M: *The skinny one?*

Mark: *Yes, with the bike.*

T: *Okay, and who is this one?*

M: *Mikey. That's the 18-year-old.*

T: *Okay. So this is one place where they don't want you to go. Is that right?*

M: [nodding]

Mark: *Why?*

M: *You know we told you that you shouldn't be at Mikey's house.*

T: *Why is that?*

M: *Because he's 18.*

Mark: *There's no law saying I can't go out with 18-year-olds!*

M: *Yes, there is.*

T: *Wait a minute; you're saying there's no law, right?*

Mark: *Mm hmmm.*

T: *Okay, but the law that you live by is your mom and dad's law. They create your law. You don't just live by police law; you live by their law. That's what this is about.*

F: *Take this Mikey. I've talked to him, Mikey, about my son* [pointing at Mark], *about getting him off drugs, off pot, and all that. Mikey is 18.* [to Mark] *Did he talk to you?*

Mark: *Yeah, he did.*

T: *What did he say? Tell us what he said to you, Mark. What did he tell you?*

Mark: *He said, "You're not going anywhere, you're not running away, you're staying home." He doesn't want me running away.*

T: *Why?*

Mark: *I don't know.*

T: *Because he thinks it would be bad for you or what?*

Mark: *Yeah.*

T: *Yeah. Did he say that?*

Mark: *No.*

T: *No, but you know, you think that's it? So, is this a place* [pointing to map] *where, in the past, you got marijuana?*

Mark: *I'd get it from another place.*

T: *Okay, but is that one of them?*

Mark: *He has it.*

T: *Okay.*

M: *Okay, Mark, admit it.*

Mark: *He has it! He didn't give it to me!*

T: *Mark, you're speaking for yourself now. It might not be the best tone of voice you're using with your mother. You've got to let them know how you feel; you're doing it right now, okay? You're doing it. So, correct me if I'm wrong but what you're trying to tell them is that all of these places are places where they have marijuana and you could use. Is that what you're saying?*

Mark: [nods]
T: *Okay. How can we protect you from that? How can we help protect you?*
Mark: *I can protect myself.*
T: *How?*
Mark: *They know! They know I can't smoke!*
T: *Okay.*
Mark: *They know!*
F: *I told them that, too: "If he smokes and I know he got it from you, you're gonna be in trouble."*
T: *Okay, let's go back to the neighborhood.* [motioning for the map] *You want to be able to go to some of these places on your own. Is that correct?*
Mark: [nods]
T: *So, I think that there needs to be discussion in terms of how you can stay safe, how you can stay off drugs. When would you come home, what time would you be willing to come home? This is your chance. It doesn't mean you'll get everything, but we want to hear what you want. You understand? So tell us about it. Tell me, what time would you want to have to come home?*
Mark: *Well, the curfew's 6—can't change that.*
T: *Okay. Okay, so could you be home at 6?*
Mark: *Well, yeah, I came home at 6 today. I came home at 6 yesterday but I left again 'cause I was mad.*
T: *So, what will you do in the future when you get mad? Instead of violating curfew, what could you do instead?*
Mark: *I dunno.*
T: *Can you think of anything, another way to handle your anger, than getting yourself in worse trouble?*
Mark: [shakes his head]
T: *It's something we need to think about and maybe work on?*
Mark: [nods]
T: *So, still, is there anything you want to say about these places? Do you think any of them are safe places for you? Do you think all of them are safe?*

In the second half of the in-home family session, the adolescent's peers are included as part of his ecosystem and made aware of the seriousness of the adolescent's situation. The next session begins with the therapist, Mark, and his parents (M and F) who are joined by two of Mark's friends. The session ends with the friends agreeing to provide support to help Mark.

F: *He's the kind of kid that, if you say, "No," he's gonna do it.*
T: *Mm hmmm, so what I'm saying is, maybe the thing is that you all will have contact* [pointing to Ecomap] *with Billy and Manny, and Juan and Mike have constant contact with them about what they're doing and what he's doing and what their influence is.*
F: *I even told one lad's father about my son's problem: the drugs, the marijuana, what he's come here for; I told him, and in not a good way. I was pissed off.*
[Peers come to the door of Mark's house]

M: [addressing Mark's friends, Billy and Manny] *He's here but we're busy right now.*

T: *Wait, do they understand what's going on with Mark?*

M: *Yeah, they know.*

T: *Okay, because I was wondering if this would be a good time to explain how serious this situation is.*

M: [to friends] *I don't want to put you on the spot but come in here, because Mark really needs your help. You guys are his best friends.*

T: *Hi, how are you?*

Friends: *Good.*

M: *Please have a seat.*

T: [to M.] *Do you want to maybe take this opportunity to talk to them a little bit about what's happening?*

M: *Mark has a 6 p.m. curfew. Did you know that? Did he tell you about that?*

[Friends nod.]

M: *Okay, he drew this map. This is your house, Manny, this is yours, Billy, this is ours right here, this is Mikey's, and this is Juan's. Basically, we wanted to know where he goes around the neighborhood. Okay, you guys are his best friends, and he likes to hang around with you guys. Now, Mark has a problem with smoking pot. I know you guys smoke pot, too. That's your business. My business is here. Mark cannot smoke pot; he has a curfew. He's gotta be home and his urine has to show no drugs. That's what we're waiting for him to do now. He's got a legal problem, a court problem. If Mark does not follow these rules, he's gonna go in for 3 years for that car that somebody else stole. But he is charged with it; it's a felony. He had a battery charge in school involving a teacher. You see what I'm saying? His anger is getting bigger, his situation is getting worse. So, Mark needs help. When he comes to you guys' houses, he cannot be smoking. If you guys have it, don't show it to him, keep it away from him, okay? Remind him, say, "Remember, be clean." Because you guys don't have any legal problems. Whatever you do is your business. And I'm not going to go run and tell your parents. But I need your help because we cannot do it alone. Mark needs help because it's hard to stop smoking.*

T: *If you are really his friends, tell him that you will help him. Help him not to get in any further trouble.*

M: *And this is no joke. I'm glad you guys came by. I know you feel weird sitting here. You feel like, "Oh God, what are they gonna say or do? Are we gonna get in trouble for this?" No, I am glad you came by. Because that way we're able to tell you. This way when I see you around and say, "Hey listen, where's Mark?" or whatever, you'll understand where I'm coming from. You see what I'm saying?* [The friends answer yes.] *And like I said, if you guys wanna go someplace, I'll be the taxi. I'll bend over backwards for Mark and for you guys, but he needs help.*

T: *Yes, he's in trouble.* [to mother] *Do you think it would be all right for them to go in his room now and talk with him? Is that all right?*

M: [motions for the friends to go; after a few minutes, all the teens return to the session]

T: *I was talking about the 18-year-old* [Mikey]. *Didn't they say they don't want you hanging around him? Why?*

Mark: *Because he's a bad kid.*

T: *Okay. So that's what they said. That's what your friends are saying.*

Mark: *I know he used to be, but he's a lot better than he used to be.*

T: *Yeah, but they still ask you not to hang out with him.*

Mark: *Yeah.*

F: *I'm asking you not to go there. We gotta do something about it, okay?*

Mark: *They know him, right? But you don't hang around him, do you?* [friends nod]

T: *When you were in your room, your mom did a really good job, I thought, of explaining to these guys about the legal stuff. Obviously, these guys like you, so we asked them to help you stay straight, get this together so that you don't go away. And they said yes. How are you guys gonna help him? 'Cause you are his main guys, you are on his map* [pointing to the Ecomap]. *Billy and Manny, how can you help him? What can you do?*

Friends: *Hang around with him more? And not hang around with Mikey.*

F: *You guys know that he cannot touch marijuana. If you guys light up and he's in the group, the secondhand smoke would go to his bloodstream and show in his test.*

To accomplish intervention in these various systems, the therapist must be active, persistent, and upbeat about the possibilities for change. In some cases, the therapist can work preventively, being sure that all concerned extrafamilial influences are working in a manner consistent with the therapeutic goals. Decisions about how best to work with extrafamilial persons are made by the therapist, and the family is critical in revealing and making suggestions about who needs to be included in this therapeutic intervention ring.

Key Concept:

MDFT accesses, enlists, and organizes prosocial community activities and options for teens, thereby supporting the development of interactive bridges among and within extrafamilial systems.

MDFT explores how multiple systems can be used by the family or individual when developmental, relational, or structural challenges emerge. Essentially, MDFT catalyzes positive relational and systemic resources that were previously unavailable and/or unrecognizable to the individual or family. Therapists must establish and maintain therapeutic alliances with the adolescent, the family, and multiple nonfamilial subsystems. The emotions within and between these multiple systems stemming from environmental stressors, past or current conflicts, and developmental shifts associated with the transition that is adolescence require the therapists to operate flexibly. Therapists employ assertive engagement strategies while an agenda is established that supports development of an interactive bridge between and within systems. MDFT therapists meet individually and jointly with systems that support the clinical agenda. The community-based focus of the model supports meeting with these systems in their environment (unless it is clinically contraindicated). Clinical services are framed in sessions with nonfamily systems to promote bringing them on board. MDFT goals are presented in terms that highlight how these services can be conducive to their organizational objectives.

Interventions To Improve School Behavior and Academic and Vocational Functioning

A primary focus in the extrafamilial module of MDFT is on the adolescent's functioning in school and/or job-related activities, including vocational training. Teens receiving treatment for drug abuse and associated behavioral problems frequently have few academic successes and tend to have low commitment to school (Chatlos, 1997; Hawkins, Catalano & Miller, 1992). They may have already dropped out or might be on the brink of dropping out of school by the time they reach treatment. A parent's endorsement of the importance of academic success is a strong predictor of positive outcome in MDFT (Dakof et al., 2001). Improving the teen's school performance and behavior and increasing his or her participation in vocational or job training involve therapist interventions with the youth, the parents, and the extrafamilial systems to support these efforts (Rowe et al., in press). Reconnection to school and success in academic pursuits are among the most important areas of work in MDFT because they are critical components in the process of creating a prosocial, productive trajectory for the teen. Work in this realm is one of the most direct ways to bolster protective factors for teens. Success in school or jobs, or both, gives teens a sense of accomplishment, a powerful experience of competence (and frequently of reversing a spiral of failure), and a tangible developmentally adaptive product or outcome (either a GED or high school diploma) that set them on a positive life path and provide new relationships with healthy peers and positive adults. Therapists work closely with school personnel to institute changes in the youth's school functioning, including integration of special programs, tutoring, and vocational training.

These changes necessarily involve cooperation from school officials, a challenge because school personnel frequently become disheartened with, and unmotivated to help, problem students. School officials may have already tried to support and change aspects of the school environment to accommodate a problem student. When a therapist enters with a request to do more, he or she may be perceived as demanding or unreasonable. A therapist's clinical skills are not reserved solely for interactions with the family and teen. They are also instrumental in working with extrafamilial sources of influence, including school and juvenile justice personnel. Therapists are taught to think of their actions with these influential others as no less important than, and as requiring the same kind of clinical expertise as, their actions with the teen and parents.

To achieve gains such as reconnecting the youth to school, improving the teen's behavior in school, and improving his or her academic performance, several interconnected interventions are linked to and integrated into the overall treatment plan to address school problems. These interventions reflect the MDFT philosophy and treatment modus operandi multiple system assessment, strategic thinking, and a formulation of multiple target behaviors, each of which may require several steps, different methods, and contact with different people involved in the problem. Research in this realm is guided by at least two working assumptions.

First, there is the fundamental belief in the importance of and commitment to working in the developmentally important realms of school performance and vocational preparation. These focuses are considered instrumental aspects of adolescent substance abuse treatment, given the interconnectedness of dysfunction as well as the need to help teens succeed not only in transforming a drug-abusing lifestyle but also in creating a pathway away from negative influences. School achievement and job competence have direct implications for helping a teen reduce or stop his or her drug use. These activities are part of the new social and relationship fabric that is woven into therapy. This new context creates new social structures, capabilities, and relationships that are incompatible with drug use. School achievement and job competence are examples of outcomes that protect against relapse and affiliation with antisocial and deviant peers.

Second, the therapist must realize and accept that this work will be difficult, may not be met with enthusiasm by most school officials, and will make the treatment of the teen much more complicated than is the case with more simple, intrapersonally focused family- or teen peer-focused models. School officials frequently are demoralized by, or sometimes are actively hostile to or reject, a clinician's efforts to advocate for the problem teen, to ask questions about him or her, and to request accountability from the school to help the student succeed. MDFT therapists are knowledgeable systems interveners. They are able to negotiate within and among the boundaries of multiple systems including juvenile justice, school, and family and peer cultures. The clinician's work in the school arena is an attempt to facilitate change in a system of developmental influence that too frequently fails those teens who need the most help. A therapist's advocacy position, assumption of leadership, creation of motivation and urgency, facilitation of good communication and problem solving, and emphasis on positive week-by-week outcomes, in the context of demoralization and previous failure (of the school vis-à-vis the teen and the teen in the school context), can create stress. The therapist realizes that he or she is not setting out to change the school policies per se but is simply working to achieve new outcomes relative to the particular case. Several elements are emphasized with the school officials:

1. Reasonable and possible practical outcomes for the teen
2. The belief in and support for the influential nature of the school context in achieving prosocial outcomes with each teen
3. The notion that the therapist takes the teen's school performance seriously, understands interventions in this realm to be a key part of drug treatment, and intends to actively promote outcomes for the teen in school.

These emphases help soften and make more tolerable the perceived and actual demands made by the therapist's assertive stance to improve a teen's school outcomes. If school officials think of the therapist as an advocate for some other cause, such as changes in school policies relative to all problem students rather than a motivation that stresses demands being made on behalf of the therapist's client, they are likely to dismiss the therapist's efforts and not to cooperate.

The balance that the therapist is trying to achieve is not unlike those in other areas of MDFT intervention and change. Support is always mixed with challenge and requests for change in one or more arenas. Change in one realm is used to prompt and bolster change in others. The following section gives the concrete steps taken by the therapist who would like to improve the teen's school or job functioning in the most direct, expeditious, and effective way possible by intervening on the family's behalf relative to the school.

First, a staff meeting with all relevant school personnel is arranged as soon as the adolescent begins treatment to determine whether the teen is in the most appropriate educational placement. The therapist gathers information about the teen's school history and current performance from all relevant sources. Such information includes grade reports, feedback from teachers, and the adolescent's own impressions and may include the exceptional student education (ESE) program, psychoeducational testing, and the individualized education plan (IEP). All available school resources (e.g., dropout prevention programs, vocational rehabilitation, alternative school programs) are assessed and, if necessary, used to provide informed feedback to the school and family regarding the most appropriate course of action (e.g., transfer to a new classroom or alternative school) for the adolescent. Although the school retains official responsibility for acting on recommendations, the therapist's close tracking of these matters is often helpful in achieving the best fit for the adolescent. Sometimes, the therapist provides links with services that the school is not able or willing to offer. One example is using teachers in training at a local university for free individual tutoring services. Other agencies may assist in providing resources for academic remediation. For example, the family service planning team at the county community mental health center often has discretionary funds available for such services.

Relationships with teachers, counselors, and administrators are developed and fostered throughout treatment. Therapists actively encourage and coach parents on how to connect or reconnect with the school. For some parents, this contact is the first time they have interacted with school authorities. The case example of E. illustrates some difficulties the therapist may encounter and the proactive stance that is necessary to facilitate positive, adolescent-focused activation of the extrafamilial school environment.

Case Example: E

E. is a learning disabled (LD) student in middle school, who at age 14 was 2 years behind in grade level and reading at the third-grade level. When he entered the MDFT program, he had recently been transferred from juvenile detention into a mainstream high school classroom serving emotionally handicapped students with high reading levels. His educational records, however, had not been transferred from the middle school. He "hated school" and was failing, but he attended despite his deep frustrations. E. understood that something was wrong with his academic placement and knew that, although he was failing his classes, the school was also failing him. Because of this understanding and the strong relationship he had with his therapist, E. accepted her advocacy with regard to school. The therapist began by requesting a meeting with school personnel. Her goal was to set up a school staff meeting; communicate to the school staff that E. was, in fact, functionally illiterate; and obtain records from all his past schools to corroborate his difficulties and get information on what avenues had been pursued to facilitate school adaptation. Present at the meeting were the head of the ESE program for the school, one of his teachers, and the behavior modification specialist. Unfortunately, the school meeting went poorly. The school personnel did not have E.'s records, offered only negative feedback about his behavior in class and lack of responsibility for his assignments, had minimal information about his reading and writing levels, and pessimistically rejected the therapist's requests for changes in his educational plan.

Because the school had clearly not met E.'s educational needs and did not appear willing to do so, the therapist contacted the executive director of the ESE program for the district, who recommended that she contact the regional director for the emotionally handicapped and learning disabled program. In response to the therapist's systemic activation attempt, the regional director convened a multidisciplinary team (M-Team) meeting, including all school, county, and regional personnel mentioned, as well as the therapist, to assess E.'s needs. The regional director ordered a psychological assessment, a complete vocational interest inventory, a reading tutor, and a private reading program to meet E.'s educational needs. His IEP was reviewed as part of the M-Team meeting, and the therapist pointed out that all the goals in this document pertained to the student's behavior. None of the goals addressed how the school would meet his academic needs, as required by the Americans with Disabilities Act. Several changes were made to the IEP, and the outcome of the meeting was the decision to enroll E. in a half-day remedial program at the high school, with a half-day of vocational training to prepare him for work after graduation.

These major steps in changing E.'s educational plan would not have been accomplished without the therapist's strong and effective advocacy. Fundamental to that intervention, however, was the therapist's knowledge of how the school system works and her experience in advocating for teens. Therapists' knowledge base of school system procedures and policies (which parallel the procedures and policies in juvenile justice work) is defined as clinical skill in the same way that their work with the teen or parent constitutes therapeutic expertise. These skills are no less important than any others in MDFT. This case illustrates how advocacy provides an effective way of combating the hopelessness and helplessness that permeates these families' lives. The responses of the school system to the therapist's advocacy engendered a sense of optimism that empowered this family to believe it could have effective interactions with the school and other systems leading to changes in E.'s life.

The clinical team also explores the option of tutoring adolescents struggling in certain classes or those with obvious problems in learning. Success in this area can have positive effects by boosting the teen's level of academic or scholastic functioning, reconnecting the teen to the school, providing a sense of pride and accomplishment in schoolwork done well, providing contact and interaction with a prosocial adult, and maintaining structure during the critical afterschool hours when the teen might otherwise be engaging in problematic behavior. This individualized attention to basic skills is consistent with the types of remedial academic programs that are recommended for high-risk adolescents (Dryfoos, 1991). Again, this intensive work is done because school disconnection and failure are consistent predictors of chronic antisocial behaviors and substance abuse (Flannery, Vazsonyi & Rowe, 1996) and because success in these realms is an important correlate to creating a drug-free lifestyle. MDFT therapists have been creative and resourceful in procuring tutoring services at no cost. The case example of S. illustrates the use of tutoring in MDFT. In this case, a practicum graduate student was recruited from the University of Miami School of Education's Learning Disabilities program.

Case Example: S.

S. was an intelligent teen who failed a grade in school because of involvement with drugs. She was held back and became concerned about completing high school, passing her State competency/achievement tests, and keeping up with her course work. She very much wanted academic help. S., her therapist, and S.'s family discussed her options, and all parties agreed on tutoring. The therapist spoke with the tutor, describing the situation and explaining S.'s needs, and the tutor agreed to work with the teen. The therapist and tutor went to S.'s house, and the tutor quickly developed a bond with the family. S. and her tutor began meeting twice each week for 3 months to prepare for her competency tests, and the tutor checked in weekly by phone with S.'s therapist. The tutor responded well to S.; she was sensitive to her but firm about her work. The tutor's continual affirmation enabled S. to achieve a sense of proficiency. By the end of the semester, after 12 weeks of work, S. passed her competency tests, receiving her highest grades since elementary school.

In addition to assessing and focusing new attention on progress in school skills and academic functioning, therapy also gives early attention to job skills and vocational training. The therapist might encourage the teen's pursuit of appropriate part-time employment (while closely monitoring school performance) to structure the adolescent's time productively, to provide a source of legal income, and to teach the youth important lessons about the world of work and about managing relations with adults in authority. Sensitivity to the socioeconomic background and needs of the adolescent and his or her family is an important component of this approach. The therapist remains in close contact with the school and, together with the school and the parents, emphasizes the primary importance of the adolescent's academic pursuits.

On occasion, the therapist, teen, and family decide together (given the results of a comprehensive academic/vocational assessment) that the teen would benefit more from a vocationally oriented track than from a purely traditional academic approach. The adolescent may have had excessive absences or failing grades, may have lost motivation for and interest in school, or may have experienced such severe failure in the academic realm that his or her abilities have been badly compromised. He or she may be far behind others in his or her grade level and reading or math skills, and his or her confidence may be depleted. These teens frequently want simply to drop out of school altogether and are well on their way to dropping out because of factors such as excessive absences. Yet, the motivated and resource-aware therapist can make available a variety of other options. Therapists link school and community services to promote more productive vocational planning and training. Typically, an adolescent may pursue a part-time school and part-time vocational training track, in which the teen spends half of his or her school day learning job skills. If it is determined that it is not beneficial or possible for the adolescent to remain in regular public school, he or she may enter the adult State vocational rehabilitation (VR) system. In this situation, the therapist facilitates contact with VR agencies and finds ways to develop the life skills that are needed to mobilize and organize the youth and his or her family to access these services. The services, however, are provided through the agencies. When the teen enrolls in a program of this type, the therapist may visit the adolescent in the program, visit with a teacher or mentor in the program, and use the events and skills learned in VR in the treatment program. As always, coordinating MDFT program components is critical.

When an MDFT therapist facilitates a link with the State VR office, the first step is for the adolescent to be assigned to a VR counselor. This person becomes responsible for introducing the VR process to the adolescent and his or her family, and this counselor becomes the contact person for the therapist. The therapist turns direct involvement in this area over to the VR counselor but maintains close contact with him or her. One strategy that may be helpful is to arrange for the same VR counselor to work with each adolescent whom the therapist has referred. The VR counselor then becomes familiar with the issues relevant to a particular population, and a strong relationship may develop between the therapist and the VR counselor.

Next, a comprehensive vocational assessment is conducted that includes not only the traditional, standardized interest inventories but also interviews with the adolescent and his or her family and an assessment of work skills. This type of individual, person-centered, and relationship-oriented assessment protocol is recommended for this population because questions exist about the application of standardized interest inventories alone to adolescents with severe behavioral disorders (Bullis & Gaylord-Ross, 1991; Schottenfeld, Pascale & Sokolowski, 1992).

Vocational training is then provided based on the findings of this assessment. Types of training may include enrollment in a community college or vocational–technical school, individualized tutoring, or on-the-job training. The adolescent is responsible for securing his or her own job, but the VR counselor works with the teen on job-interviewing methods and skills. This assistance creates self-sufficiency and competence and provides the teen with support in reaching this new goal of employment. The objective of getting and holding a job in the community, rather than working in a sheltered job setting, for instance, is ideal. Research literature indicates that this outcome is considered significantly more beneficial for this population in terms of experiencing an actual "real-world" job setting (Bullis et al., 1994; Bullis & Gaylord-Ross, 1991). Sheltered work settings, however, also can work well, particularly in the most difficult situations in which no other options are possible. Some programs include hands-on job coaching. This feature is particularly beneficial because teens in treatment show great deficits in work-related social skills (e.g., punctuality, getting along with coworkers [Fredericks et al., 1993]). The job coach may closely monitor the adolescent when the adolescent is beginning a job, then decrease involvement as the teen becomes more comfortable and more skilled in his or her work.

Intervention Guidelines To Improve School Behavior and Academic and Vocational Functioning of Drug-Involved Youth

1. The therapist must be clear about the fundamental importance of assessing, focusing on, and obtaining outcomes in the school or job domain of the teen's functioning. Positive changes in these realms are important supports and motivators for changes in drug use.

2. The therapist must be clear with the teen and parent about this treatment focus and explain why it is related to the teen's success in the program and how success in school or with a job connects to establishment and maintenance of a drug-free, prosocial lifestyle. Obviously, these are not one-time communications. They are stated and discussed at treatment's outset, as well as throughout the process of the program.

3. Family members and teens need help in understanding, negotiating, and navigating school, academic, and vocational systems. Most clinically referred teenagers have experienced frustration and failure in school and job realms. Many have given up hope that any new effort on their part can yield new results. A therapist should not assume that adolescents and parents are knowledgeable about school policies or procedures or

are able to interpret correctly complex or cryptic messages from schools. Just as therapists intentionally mediate and position themselves between the juvenile justice system and the youth and his or her family, therapists adopt the same stance between the adolescent and his or her family and the school system. Although the ramifications and implications of each set of these systemic transactions are different, they have similarities. Therapists conceive of themselves as part advocate, change agent, and facilitator in their work with schools and legal systems. Their bottom line, as always, is the youth and his or her family—the therapist in each context is trying to promote positive prosocial behavior, facilitate a fair and facilitative process between the social institutions and the youth and his or her family, and help the family keep its focus on how to achieve positive and healing outcomes and concrete alternatives and success in each of these realms.

4. School personnel will not necessarily be motivated to cooperate with the therapist's efforts to determine how to make the teen's school experience more successful. Therapists walk a tightrope between too much and too little advocacy and between too much and too little understanding of the parents' and school's previous experiences with a particular teen. A therapist's clinical skill and systems knowledge are instrumental to successful work at the interface of the family, teen, and school systems.

5. The therapist is an advocate vis-à-vis the school and a coach vis-à-vis the teen and parents. The therapist works with each subsystem to prompt new attitudes and behavior relative to the other subsystems. Just as the therapist works with the teen alone to mediate and prompt new behaviors with the adolescent's parent and intervenes with parents individually to help broker a new relationship with their teen, the therapist also works with the teen and parents about becoming more involved at school and prepares the family for school requests and meetings. The therapist directly interacts with school officials to advocate for the family's needs and facilitates contact and adoption of a positive attitude toward the teen and parents. Therapists also help parents and teens develop more positive attitudes and action plans regarding school.

6. Emotional reactions by school personnel, such as fear of the teen's continuance in a particular school, or on the youth's or parent's part as well as schoolwork/academic ability demoralization issues, are commonplace. Strong reactions to a therapist's efforts by the family, adolescent, or school should not deter a therapist from a thorough multiple-system assessment and formulation and implementation of an action plan (e.g., testing, tutoring, behavioral management, job training, alteration of classes taken).

7. As the leader of this therapeutic effort, the therapist must convey an upbeat attitude to all parties. This positive energy must be accompanied by a solid, reasonable, and workable plan, in which everyone's roles and responsibilities are enumerated and the amount of time that can be committed by each team member is stated.

8. Well-articulated plans can still fail. Knowing how a plan may fail is an important part of being a therapist. Knowing how to minimize slippage or outright failure is vital. Enlisting and motivating family members and the teen in the daily behaviors required to help the teen succeed in school are key to success. Good plans that are underorganized or not sufficiently attended to on a daily or weekly basis are likely to falter or fail.

9. Titration of a therapist's involvement in these organized therapeutic plans is always a challenge. Early on, the therapist is active and directive in setting up a plan, and although the family members and school officials are involved in crafting suitable alternatives, the therapist must be prepared to supply considerable energy and ideas to the new plan. Over time, of course, the plan to help the teen reconnect to school and succeed academically is something for which the youth, parent, and school must be responsible (relative to the individual roles each has to play). Thus, as the weeks of treatment unfold and the teen's new plans for school or a job are implemented, the therapist becomes more of an outside consultant rather than an inside player.

10. Finally, as is the case with MDFT therapists generally, the therapist watches and calibrates school functioning change relative to other areas of work. Gains in other realms, in the family environment or parent–adolescent relationship, for instance, are used as supports and motivators for new discussions and plans in other, related realms of functioning. The MDFT therapist, in collaboration with the family members, orchestrates the focus and effort in the therapeutic system according to the overall individualized treatment plan and in the unfolding of problems and successes in each area of work. Changes in school functioning facilitate access to and work on the self of the teen, helping him or her, for example, develop an identity that includes self-efficacy, competence, and the capacity to overcome previous failure and obstacles. Changes in school behavior or academics also can be used in a therapist's work with parents. Parents of clinically referred teens can be pessimistic and negative in their view of their teen's abilities and potential. Therefore, when change in school behavior or academic involvement begins, this evidence of possibility and hope for a new, prosocial, non-drug-using future is brought to the parent and family sessions.

Decision making

A challenging aspect of the academic or vocational module for the therapist may lie in determining the combination of academics and vocational training that would be most beneficial for the adolescent. The case example of L. illustrates this decision-making process.

Case Example: L.

L. is a 16-year-old who was not attending school when he began treatment. He had been referred to an alternative school because of truancy, smoking marijuana on campus, and other behavioral problems, but he had not begun attending the school. He was in ninth grade and had been held back twice; he had one more chance to pass ninth grade. The therapist decided that the most immediate concern was that L. attend school during the day so that his time would be structured. Because the alternative school held classes only at night, the therapist decided to pursue L.'s readmission to his original high school.

The therapist first contacted the high school assistant principal, who was adamant about not allowing L. back. The therapist then contacted the director of alternative education for the county and described the goals of the program, the adolescent's involvement in treatment, and the role of the therapist in advocating for him. The director was responsive to the therapist and instructed the high school to reenroll the adolescent.

The next step was for the therapist to meet with the school counselor. Together, they decided which classes would be most appropriate for L. to take to accrue some credits toward completing ninth grade. They also arranged to meet 2 weeks later so that the teachers would have a chance to observe L. in class. Only two teachers attended the meeting. Although they stated that L. was not having any academic or behavioral problems, the therapist and guidance counselor agreed to schedule a second meeting a few weeks later with more of L.'s teachers.

At the second meeting, it was reported that L. had failed all of his midterms. He had missed several weeks of school in the beginning of the year, and he was in danger of failing ninth grade for the final time. Throughout the semester, L. had expressed an interest in attending night school. He did not feel confident about his academic work and did not think he could succeed in day school. His mother had begun investigating private schools where he could receive some vocational training, but they were expensive. The therapist suggested that they explore the possibility of a part-time school and part-time vocational training program offered through the State VR office. Both L. and his parents were excited about this idea.

L., his mother, and the therapist attended an intake appointment at the VR office. The VR coordinator explained the program, gathered some information from L. about his work-related interests, and gave suggestions about which services might be most suited to L.'s needs. The VR coordinator began coaching the adolescent immediately regarding job-seeking skills. The coordinator scheduled the vocational assessment. L.'s reaction to the intake meeting was positive. He enjoys working with computers and is excited about the possibility of pursuing work in this area.

In conclusion, the academic and vocational portions of the adolescent's world are complex and multifaceted, and the therapist must be adept at negotiating extrafamilial systems and advocating for the adolescent to address these areas comprehensively. When the therapist is successful in this endeavor, as illustrated in some of the case examples, the effect on the adolescent can be extremely positive and contribute to improvement in his or her overall functioning.

Interactions with teachers and school counselors identify and promote goals that are mutually supportive, that is, enhance parental investment in the adolescent's development and the school's desire to be supported by parents. MDFT clinicians work to identify ways that they can be supportive of the school's goals (just one of multiple nonfamilial systems) so that potential boundary and role definition sensitivities are transcended. The objective is to facilitate positive interactions that embody a common focal theme pulling together for the teen and family. Supportive and followup efforts by clinicians in their interactions with families and schools determine how sound this newly developed resource bridge will be. To help adolescents and families be more connected to and involved with multiple subsystems, MDFT clinicians meet at a variety of locations and with various combinations of family members and extrafamilial systems. Decisions regarding with whom and where to meet are made in accordance with the overall clinical objectives and the individual features of the case.

As relationships are reinforced or built, traditional relationships between and within family and nonfamilial systems are challenged in a manner that is intended to promote positive change. The challenges promoted through MDFT are often experienced by the family and nonfamilial systems with some hesitation. This situation is true at the outset of MDFT as well as during ongoing contacts. Hesitation (in familial, individual, and nonfamily systems) should not be attributed to resistance to change or resistance to alternative interactions, for example. Rather, this hesitation should be understood in terms of the natural difficulty of facing and experiencing challenges arising in this kind of work (Liddle, 1995).

Key Concept:

A teen's or parent's hesitation about involvement in a treatment program is normal. The therapist's job is to facilitate the growth of motivation in treatment.

Collaborating With the Juvenile Justice System: Probation Officers

In collaborating with the juvenile justice system, therapists work hard to develop a relationship with probation officers. This is extremely important work. Probation officers have a certain amount of influence over the disposition of a teen's case. They can recommend for or against placement. If a teenager needs to be placed, probation officers can recommend a treatment facility over detention. They can use their influence to control the timing of events with the court. This can be critical because there are often few individuals or systems willing or able to exert themselves to keep teenagers in the family, school, and community. Therapists frequently find themselves in the position of needing to buy time to engage teenagers and families in treatment programs. This is the case when a teen's legal troubles are voluminous and complex and, in a not unrelated process, his or her family presents as hopeless about change. The relationship with probation officers is also important because they will have access to valuable resources with which the therapist and family may need connections—training and job programs or school personnel and treatment facilities.

The relationship with the probation officer begins when a therapist places a call to a probation officer at the very outset of a case. The therapist asks about the probation officer's experience with and knowledge of the teenager, whom he or she often has known long before the therapist meets the teenager. The therapist asks for the probation officer's "take" on the teenager. Does the probation officer have any opinions about or insights into what has happened with the teen and family? The therapist introduces the subject of collaboration early in the conversation, making sure the probation officer realizes that the therapist is taking into account the pressures of the probation officer's caseload. The therapist asks the probation officer what times are convenient to check in, because the therapist knows that the probation officer is always busy and often out of the office. The therapist inquires about the nature and frequency of the probation officer's meetings with the teen, the frequency of urine drug screens, and the expectations for the teenager's cooperation. The therapist assures the probation officer that the clinical work is, in part, oriented to helping the youth and his or her parents meet the requirements and obligations of the juvenile justice system.

The emphasis is on what the therapist can and will do and only secondarily on what the probation officer may have to offer. The therapist stresses not wanting to add to the probation officer's burden and that the therapeutic or program focus is on the family and coordination of effort. The therapist asks about upcoming court dates and gets the probation officer's take on what may happen there. The therapist explains the philosophy and parameters of the treatment program but is careful to avoid clinical buzzwords and elaborate analyses. Some probation officers expect to find treatment programs are not practically oriented. The therapist looks for common ground and points of connection.

All efforts in this early phase of a case are aimed toward the collaborative relationship to follow. The therapist may ask, "Can I count on your support of our program's efforts? Is it okay with you if I call you and check in regularly, so we can share information and make sure we're on the same page?" Beyond alliance-building, however, the clinician must work to build and maintain a working intervention-oriented relationship with the probation officer.

Therapists and probation officers may represent radically different orientations and ideas about what is needed to help the teen. Clinicians often must convince probation officers that the focus on parent–adolescent relationship dynamics will pay off in practical terms in better parental monitoring and the development of greater emotional resources in the family. It is best to avoid abstract language, to use dialog (conversations between colleagues with a common purpose), and to collaborate in the best interest of the youth. These conversations must inform the probation officer of the parameters and intentions of the program.

Therapists and probation officers focus on actual case material, using it to forge a relationship and build collaborative bridges. "You know, I agree with you about how hard it's been for Mrs. Williams to manage things, and she's done a pretty bad job in the past setting limits with John. I think she's depressed, and we're getting her some help with this so that she can feel less overwhelmed. One of the things we do a lot here is help parents see how they can take care of themselves and their kids at the same time. It would be good if we had a little time. Is there any way we can slow the placement process down? I think we've just gotten started."

It is important for therapists not to let the relationship languish during periods when things are going well.

The interaction and interdependence of MDFT and the juvenile justice system

Most probation officers focus on the teenager as an individual; MDFT has a family focus. The MDFT clinician is interested in identifying the internal logic of teenagers' choices and difficulties while helping the adolescents identify their motivations, enhance their options, and improve their problem-solving skills. Even the probation officer who is highly motivated and involved "pulls the plug" on treatment. Therefore, the therapist must assess carefully the probation officer's motives and style before proceeding.

Likewise, the therapist must evaluate how close parents are to abdicating total responsibility for the teenager and how disillusioned and angry they are. What external and internal resources do the parents bring to building a more reasonable relationship with their teenager?

The probation officer most likely will be confronting a teenager whose attitude toward authority is distrustful and who may behave in an outwardly defiant manner. The notion of being monitored by an outside authority—the juvenile justice system—that has the power to influence events in her or his life is likely to stir up any and all of the adolescent's current or lingering resentments toward systems in general. Pride and self-respect may demand that an adolescent not submit to systemic authority as a matter of honor. "Beating the system" is, for some teenagers, an ingrained response. For some teenagers, there may be a family legacy of hurts, disappointments, and slights meted out by the systems with which the teenagers have been compelled to interact.

A collaborative, purposeful, youth-oriented alliance

Every new relationship with a probation officer contains within it the seeds of either advancement of the teenager's agenda or a potentially disastrous and premature ending to his of her hopes of advancing that agenda. If the teenager is able to perceive both the necessity for and the possibility of a collaborative relationship with the juvenile justice system and the probation officer as that system's representative, then the teen's attitudes toward the system will change. The therapist lets the teen know that if he or she participates in the treatment program, the therapist will work hard to slow things down with the probation officer and try to affect any court action. Most teenagers are happy to have the therapist working with them in this manner, but a number continue to have urine screens that show drugs are present, miss appointments with their probation officer, or get into more trouble.

The therapist responds to missteps in a challenging but supportive way as well: "Look, I need you to be doing your part in this. I can't help things change or slow things down if you're doing this stuff." In addition, the therapist may be able to help a parent support the necessary actions on the part of the teenager. The therapist at all times encourages parents to work together with other adults—therapist and probation officer—out of love for and commitment to their teenager.

Sometimes parents are reluctant to state their disagreement with a probation officer's plan for their teenagers, and the therapist must help them articulate such differences so that a reasonable plan can be agreed on. Sometimes parents feel their teenagers do not deserve another chance when they have gone to bat for them so many times before; sometimes, however, it can be equally difficult to convince parents to do things that are not purely in support of keeping the teen in the probation officer's good graces. Therapists may have to encourage parents, for instance, to inform a probation officer about violations of probation when this is in the service of helping a teenager confront the consequences of his own actions. These dilemmas offer opportunities and are at the core of the therapist's work with parents.

A therapist needs to discuss what underlies a "bad attitude" toward the legal system and the ramifications if this attitude toward the probation officer persists. The therapist needs to talk about how hard it is for teenagers to be monitored and how the teen may be tempted to chafe at such an oversight, with a view toward problem solving together. These statements are put in the context of the potential influence that the teenager can have over the outcome of events.

More concretely, the therapist monitors the adolescent's attendance at appointments with the probation officer, shares contacts and resources with the probation officer, helps the teenager prepare for court appearances, discusses how to use the probation officer as a resource, and encourages parents to do these things for and with the teenager.

Additional Collaborations With the Juvenile Justice System: The Important Subsystem of the Juvenile Court Judges

In addition to working with probation officers, MDFT therapists are frequently in contact with other members of the juvenile justice system, particularly the judges who preside over juvenile court. MDFT's focus makes it imperative to inform and educate judges about the treatment model. As with probation officers, it is necessary to make a similar effort with the juvenile court judge who is presiding over the teen's legal case because he or she can influence the process and outcome of a case.

Often, a therapist will also need to appear in court because the judge will request an update on the teen's progress in treatment. A judge's prior awareness of how the treatment works, what is required of the adolescent, and some broad-level details about the course of treatment are extremely helpful when the therapist must report to the court.

The judge also must have knowledge of how the therapist works, why work is done in a particular manner, and what the strengths of a home-based model are. This knowledge becomes even more significant when there is conflict involving the case.

Two of the most frequent causes of disruptions to cases on probation are violation of probation (new charges occur) and continued conflict in the home. A violation of probation and further involvement with the juvenile justice system may be the result of something that allegedly occurred before the adolescent entered treatment, or they may be the result of a new crime committed while the adolescent is in treatment. If the judge truly understands how MDFT works and the theory and science driving the treatment, he or she is much more likely to permit the teen to continue in treatment.

Another frequent reason for disruption is continued family conflict; the parents believe their adolescent is ungovernable and request a hearing because they do not want to continue with home-based treatment. If the judge understands that the problem is the family system and not the adolescent, he or she is more likely to require the family to keep the juvenile in treatment and instruct the family that it must be involved in and a part of treatment. The case example below illustrates the importance of establishing contact with a judge and informing him or her of the theory and science behind the treatment modality.

Case Example: P.

A 14-year-old Hispanic male, P., came to the MDFT treatment program with a diagnosis of ADHD, cannabis dependence, alcohol dependence, conduct disorder, and stuttering. There was significant trauma as well. Abuse by the biological mother—physical and emotional—precipitated P.'s removal at age 3 from her care by the Department of Children and Families. A foster home placement came next, followed by placement with P.'s father and stepmother.

P. is currently in an emotionally handicapped (EH) placement at a special EH middle school. He has significant anger management and attachment problems and has not bonded with any individual.

P.'s stepmother frequently tries to sabotage treatment and is very jealous of any attention that P.'s father gives him. P.'s father seems to genuinely love him but believes in corporal punishment. P. states that his father hits him at times and has thrown chairs at him; clearly, his father has a temper.

In session, P. cries that no one talks to him and that his father doesn't do anything with him. For recreation, P.'s father goes fishing, but P. is no longer interested in fishing with him as he used to be. P. has very little contact with his father, and his stepmother runs the show. P. states that he hates her and feels very bitter about her involvement in his life.

Because of the conflict in the home, P. went to his therapist requesting residential treatment, rather than treatment in the home-based program.

The stepmother would also prefer P. to be in residential treatment. So P.'s family decided to go back to court and request a hearing. P.'s therapist and the therapist's supervisor felt very strongly that the biggest problems in this family were problems that would not be addressed in residential placement, where P. would only, or mostly, get individual treatment.

P.'s therapist went to court with the family. Despite there being a translator for P.'s father (who speaks only Spanish), his stepmother spoke for P.'s father. She stated that there was too much temptation in the neighborhood and that P. should be placed in a residential setting. P.'s therapist stated that she believed there were relational difficulties in the home that would not be addressed in the individual treatment offered in the residential setting.

In this situation, both the therapist and the supervisor had spent some time with the judge months before this particular case began. They had explained the MDFT model and treatment program and provided articles and news releases on the approach. The judge had absorbed the information, as was evident when he began to speak to the family. The judge told the family, "You share this problem jointly."

In addition, the judge explained to the family that adolescent substance abuse problems are different from adult substance abuse problems; because of this, it would be much better for the young man to stay in the home and receive treatment with his family.

The judge knew not only what the MDFT model was, he also had some understanding of the multiple pathways to problem behaviors and multiple pathways to treatment—and was able to elucidate this knowledge for the family. He insisted that the young man stay in the family treatment modality. In this case, the family got more than they bargained for. Neither the stepmother nor the father wanted to hear that she or he was a part of the problem. The family also learned a lesson about going back to court—it often is not necessary.

In this situation, briefing the judge about the treatment program early in the process was essential. P.'s family had to accept the judge's order, and as an influential part of P.'s environment, the judge was able to apply appropriate developmental knowledge to P.'s case.

It is important to understand that contact with a judge (an appointment for 8 or 8:30 a.m. is best) involves presenting educational information in a timely fashion. The therapist may present his or her opinion about a case in court. The purpose of the contact in chambers is to provide information relevant to the general disposition of juvenile cases and specifics about the treatment alternatives that are made possible in the program.

Juvenile court judges need to know that MDFT is a science-driven treatment alternative that can reduce recidivism, that works for teenagers, and that affects families and the entire ecosystem of a teen, including school and peers. Judges have been very responsive to the fact that MDFT includes wraparound services; that contact and crisis intervention are available 24 hours a day, 7 days a week; and most important, that MDFT is less costly than residential treatment. It is also important to convey to a judge that MDFT has been devised and tailored specifically for each teenager's developmental level and that major components of the intervention include and treat the entire family. The information that usually has the biggest impact on juvenile court judges is that when adolescents leave home and are placed in residential treatment, then released, they return to the same problems that contributed to their initial problem symptoms. But MDFT treats the adolescent, the whole family, and the problems surrounding the adolescent.

Most juvenile court judges will be interested in receiving information and talking about an alternative treatment strategy; they are interested in the treatment, not the punishment, of the teen. Some judges will show specific interest in the details of the psychology behind the theory. If the judge truly wants to hear more, it is usually more convenient to schedule a second meeting to present more details and discuss the model theoretically.

Juvenile court operates on a concept known as "therapeutic jurisprudence," or treatment and rehabilitation by means of the legal system. Most juvenile judges are interested in the children's being served and in the management of their cases; they understand that the juvenile system is different from the criminal (adult) system. Judges are also aware that the processing of juveniles is often problematic and that the system is overloaded; this makes the judges more receptive to new ideas, especially those based on proven science.

Repercussions of Lack of Involvement in Extrafamilial Subsystems

The case example below illustrates the intense repercussions that occur for both adolescents and families when therapists are unwilling to follow MDFT protocol and maintain contact with both the family and the extrafamilial subsystems.

Case Example: B.

Throughout B.'s case, the therapist had not been involved with or in contact with key persons outside the family. In an early session, he was unaware of the involvement of a "tracker" from the probation office. Once he became aware of the tracker, he gave no indication to the family that he wanted to get in touch with the tracker. In a later session, the therapist suggested the mother deal with legal aid and also get the adolescent examined by a psychiatrist. The mother responded with harsh resistance and criticism: "I come here, I ask for these things. Time goes by, nothing's done. There are no recommendations." The mother then criticized the therapist's efforts as superficial, prompting a defensive response by the therapist. The therapist finally agreed to call the school and attend a meeting with the mother.

Later, a supervisor discussed what had occurred with the therapist. The therapist was quite resistant to becoming involved with systems outside the family. He believed that the support he provided directly to the family would enable the family to deal with external systems on its own. During the first sessions, it became clear that B. was involved with a probation officer, the tracker—a school counselor who talked with the mother frequently—and, of course, with teachers on a daily basis. It now became apparent that legal aid would be brought into the case. The therapist had also been absent for a month; during that time, B. had broken into an apartment with some friends and vandalized it, as well as stole $10 from a family member's car. It became obvious that this was a crisis; eventually, B. was placed in residential care.

It is imperative that the MDFT therapist maintain close contact with key members of these systems. It is unrealistic to expect families to be able to navigate these complex and at times resistant systems on their own, much less attempt to coordinate efforts across systems. Moreover, members of external systems can provide valuable information and resources for the therapist. Conversely, an impasse within an external system can undermine work the therapist is trying to accomplish with the family.

V. Working the Model: The Interdependence of Emotions and Cognitions in MDFT

This section illustrates important aspects of the working phase of MDFT using a critical topic—the interdependence of emotions and cognitions in family therapy—as the backdrop for how to work core themes.

Negative Emotions and Problem Behaviors

Theory and data have converged to form a picture of the role of negative emotion and the development of problem behavior (Dodge & Garber, 1989). A major review underscored the "centrality of positive affect in the organization of prosocial behavior" (Collins & Gunnar, 1990, p. 393). Blechman (1990) described the relationship between moods of individual family members, their contact with one another while in these moods, and individual and family functioning. Blechman believes that "family members who are often in good moods are primed for competence and shielded from psychopathology, despite cultural, biological, and socioeconomic handicaps" (1990, p. 221). Similarly, Wills (1990) discussed how supportive relationships among family members influence the emotional states of adults and children and how emotional states and processes affect the health status of family members (i.e., through stress buffering).

Along the same lines, Carlson and Masters (1986) demonstrated how positive affect buffers children against some of the effects of negative affect. Ingersoll and Orr (1989) theorize that certain emotional patterns (e.g., being upset, lonely, tense, sad, nervous; having problems sleeping or making friends; self-destructiveness) predispose adolescents to risky behaviors. "It may be that individual styles of coping with social stresses are the primary moderating variables that increase or reduce the risk of engaging in problem behaviors" (Ingersoll & Orr, 1989, p. 405).

The regulation and expression of negative emotion have been critical topics in the clinical literature (Hooley, 1985; Koeningsberg & Handley, 1986; Leff & Vaughn, 1985) and basic research for some time. Affective processing ability has been linked to social competence in children and adolescents (Sroufe et al., 1984). Gottman's work with children and married couples emphasizes the link between negative emotion regulation and effective functioning (Gottman, 1983; Gottman & Levenson, 1984). Lindahl and Markman (1990) believe affect regulation to be a critical developmental task with couples and families. They hypothesize that a couple's ability to regulate negative affect in their marriage is linked to marital quality, which itself is related to the parents' ability to regulate negative affect in their interactions with their children. The parents' emotion regulation in interactions with their children, obviously, plays a central role in their children's predominant affective tone.

The predictive power of negative affect on parent–child interactions and child outcomes is well documented (Patterson, 1982). Frequent and intense negative emotional expression is connected to a variety of clinical problems, including delinquency (Rutter, 1980) and drug abuse (Kandel, Kessler & Margulies, 1978). The connection of emotion systems to the development of drug abuse is a core construct in a promising line of research by Pandina and colleagues (1992). Their early studies have found that adolescents with an emotional profile of pervasive and persistent negative affect, energized by a context of prolonged and heightened arousability, progress from experimental drug use to abuse.

Emotion regulation has also been discussed in terms of its adaptive functions, for instance, as a way of coping with negative self-feelings or stress (Saarni & Crowley, 1990; Wills, 1990). Three critical factors influencing emotion regulation (each with different implications from a target-of-intervention perspective)—temperament, cognitive development, and socialization (Saarni & Crowley, 1990)—are present in the case of Chris, which follows.

Emotions and Problem Solving

Clinical theory, in accord with empirical work by investigators such as Pandina and colleagues (1992), suggests that chronic negative emotion detours problem solving and, over time, erodes relationships (Minuchin, 1974). Forgatch (1989) believes that negative emotion can affect the problem-solving process in several ways.

1. It may affect the representation of the problem, making solutions seem improbable.

2. When a person is too focused on negative experiences, it can impede his or her ability to generate helpful solutions.

3. It can affect interaction because negative emotions create a climate in which people are less motivated or able to come up with a solution.

The clinical example that follows illustrates these processes. In a study with important clinical implications, Forgatch (1989) established clear links between negative emotion and ineffective problem solving involving parents and adolescents.

Emotions and Dysfunctional Family Patterns

Earlier eras of family therapy focused on overinvolved parent–adolescent relationships (e.g., Kaufman, 1985; Minuchin, Rosman & Baker, 1978). Today, in a trend that may reflect some societal processes (see postmodernism's charge of fragmentation [Gergen, 1991]), increased attention is given to disengaged family systems. Research teams see patterns of parent–adolescent disconnection and disengagement in their clinical samples (Liddle, Dakof & Diamond, 1991; Volk et al., 1989). These relationship problems, often characterized by intense negativity and longstanding resentments, have been very difficult to treat (Liddle et al., 1992).[1]

Case Example: Escalating Negative Emotion

The clinical illustration below examines one of the most difficult and, according to some (Doane, Hill & Diamond, 1991), most change-resistant problems faced by clinicians—chronic, stable, and quick-to-escalate negative emotional exchanges between family members. Interactions of this kind have been identified from several theoretical perspectives and linked to the development of child and adolescent problems (see review by Loeber & Stouthamer-Loeber, 1986).

Segment Introduction

The first segment of this case gives a "baseline" of a typical, negative emotional exchange. It illustrates progress achieved during the session. The last segment presented (segment six) occurred 30 minutes after the baseline segment. The segments show different kinds of clinical techniques; however, at a macrolevel, they are consistent in showing a single therapeutic strategy central to MDFT. Known as the *shift strategy*, this technique is used to change in-session impasses between parents and adolescents (Liddle, 1991). These emotional stalemates are broken by changing the focus of the discussion during the session. Frequently, this involves moving the conversation to a more personal level. This method accesses certain emotions (e.g., the parents' commitment and love, an adolescent's hurt feelings) while blocking, at least temporarily, others (e.g., resentment) (G.S. Diamond & Liddle, 1996). Emotions are targets of work as well as mediating variables. In this sense, they are intervention focuses that can potentiate entry into other domains of functioning. For example, a focus on emotion may be helpful not only for motivation enhancement but also for intrapersonal or interpersonal processes that can lead to the cognitive or behavioral domain. All the segments, from the baseline to the final segment, are presented in the order in which they occurred.

The case[2] involves Chris, a 16-year-old boy who is the youngest of three siblings (the older two live outside the home). Chris lives with his mother. Although his parents are separated, his father is involved in his treatment. Chris is currently on probation for drug possession and violence toward school personnel.

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[1] Although the focus is on adolescents, we cannot conclude this section on emotions and dysfunctional family patterns without mentioning the importance of parents' emotions as a major determinant of the adolescent's emotions. In a comprehensive review of emotions in the parenting literature, Dix (1991) concluded: "Perhaps more than any other single variable, parents' emotions reflect the health of parent–child relationships" (p. 4). Dix presented a systematic, clinically relevant framework for understanding emotions' role in parenting. His model emphasizes (1) child, parent, and contextual factors that activate parents' emotions; (2) the orienting, organizing, and motivating effects that emotions have on parenting once they are aroused; and (3) the processes parents use to understand and control emotions.

[2] These particular sequences were chosen for this section because they are good examples of (1) the selected clinical problem, (2) the therapy interventions used, and (3) the change process as it is currently understood.

Segment One (Baseline): Negative Emotion in Action

Mother (M): *I'm sorry.*
Chris (C): *What? At least I admit when I'm wrong. You never do. F___ you.*
M: *Well, I don't remember it that way. What I remember…*
Father (F): [to Chris] *All right, all right, don't talk that way.*
C: [to his father in a very explosive manner, sitting up in his chair, arms waving, finger pointing; the therapist sits forward, ready to intervene] *Just shut up. You don't live at my house; you don't have nothing to do with this at all. So, why don't you just leave? Just shut the f___ up. You're never f___ing there, you're never f___ing there.*
F: *I'm supposed to be there.*
C: *Even when you lived there, you were never in anything. So, just shut up.*
F: *I come here every Monday night.*
C: *You think I want you to be here? No.*
F: *No, but I come here anyhow.*
C: *I don't want you to be here, so don't f___ing lay that on me.*
F: *I'm not laying it on you.*
M: *Chris, he is your father.*
C: *He never acts like it, never. He's my biological father, but he's never acted like my dad ever in my whole life. I don't need a father now.*
Therapist (T): *Is that true?*
F: *I guess it is. If he says it is, I'll go along with that.*

This segment illustrates two important points made by Safran and Greenberg (1991) in their discussion of the role of emotions in psychotherapy. First, it shows how "emotions provide action disposition information" and, second, how "emotional responses are mediated by anticipated interpersonal consequences" (Safran & Greenberg, 1991, p. 7). Cumulatively, negative emotions of this kind are developmental threats to the adolescent's self system (Grossman & August-Frenzel, 1991). Particular knowledge like this, along with the developmental sensibilities guiding MDFT (i.e., that treatment retracks normal individual and family developmental tasks), is essential. The following passages give numerous examples of negative emotion in the life of this adolescent.[3] Some family treatment models emphasize process over content (Hoffman, 1981). In MDFT, however, the particular content of the discussion is understood as critical to the elicitation and exacerbation of the intense, negative emotional arousal. This understanding includes historically significant and contemporaneously enacted intrapersonal and interpersonal relationship themes. Themes of resentment about past hurts and the adolescent's nonacceptance of the parent's attempt to adopt a parental role are frequent in-session topics.[4]

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[3] Although we have yet to analyze these data, our clinical research has been concerned with characterizing the emotional processes and characteristics of the adolescents we see in treatment. In one of our studies, for instance, we used the Millon Adolescent Personality Inventory to assess the emotional self system of adolescents.

Knowing about emotions as action tendencies (Fischer, Shaver & Carnochan, 1989) gives a therapist the confidence to intervene in a conversation progressing down a disastrous path. During an interview or session, a therapist's behavior is informed by this knowledge. Therapeutic goals include reinstitution of the attachment between parent and adolescent. Changes in this relationship serve historically relevant purposes (e.g., healing past resentments) and present-focused purposes (e.g., successful problem solving of everyday conflicts is one area in which the renegotiation of the parent–adolescent transition occurs).

Segment Two: Focus and Framing

T: *Chris, right now, it seems to me that it's as if your whole life with your father is flashing before you. You've been mad at him for years, I mean. Is that accurate?*
C: *Yeah.*
T: *Right now, every inch of this guy is tight and really angry. Right?*
C: *Yeah.*

One aspect of dealing with emotional reactions is to focus on the appraisal of events or relationships (Lazarus, 1991; Shaver et al., 1987). Therapists' characterizations of situations are intentional and precise, selecting certain elements of the drama for focus. Understanding emotional reactions in MDFT is not an objective per se (although this may occur). Characterization or, in family therapy terms, creation of new realities (Minuchin & Fishman, 1981) or frames (Alexander et al., 1983) is a practical and at least temporarily useful accomplishment. These realities or frames are also new in-session territories of operation, as they are called in MDFT. They are intended to serve as a more workable foundation on which new work on one's self and one's relationships occur. In the previous sequence, the therapist first reestablishes the longevity of the problems—thus presenting the historical reason for why Chris' emotions would be so strong. This construction is preferable to pathological personality ascriptions that perpetuate beliefs about the other's incompetence and contribute to a chronic negative emotional tone. Then, the intensity of Chris' experience is acknowledged and named. The intent is to reduce the fears associated with this experience (both his father's and Chris' concerns about his lack of control).

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[4] Parenting is a complex area of the field experiencing a renaissance of attention and systematic study (Dix, 1991; Sigel, McGillicuddy-DeLisi & Goodnow, 1992). Elsewhere, we have described methods designed to help parents reclaim their parental role (Liddle, Dakof & Diamond, 1991). Unfortunately, these assertions of parental responsibility frequently come in the role of increased attempts at control (i.e., introduction of more control attempts into a system of relationships that already has an overabundance of control issues and attempts). Not surprisingly, our research found these behaviors to be some of the very ones that lead to greater estrangement on the adolescent's part (G.S. Diamond & Liddle, 1996; Schmidt, Liddle & Dakof, 1996).

> T: *And, Chris, you're angry at your father.*

The interpersonal aspect and target of the behavior also are named.

> T: [continues, to Chris] *You have to help us figure this out. When you get angry, what's the best way to handle this?*

This attempt to establish a particular reality first aims to demystify and disprove the apparent inevitability of emotional reactivity and failed problem solving. Second, it asserts that Chris can and should have some responsibility for communicating his concerns more effectively and helping to devise a therapy plan. It is important to affect the adolescent's participation in treatment in the presence of a parent to counter the frequently heard remark of parents that some treatments require too little of the adolescent.

> C: *I usually just tune out and try to forget about it.*
> T: *All right, but you know that's no good. That's why you're here, Chris.* [to his father] *As you know, you're trying to find a new Chris.*

Although it may have clear adaptive functions (Wills, 1990) and represents this adolescent's emotion regulation strategy (Saarni & Crowley, 1990), Chris' "tune out and forget" method is defined as ineffective problem solving. The "big picture" (Liddle, 1985) aspect of the work is invoked. This is an attempt, among other things, to help Chris express himself more effectively. Mastery and competence are important tasks of adolescence and protect against the development of problem behaviors (Dodge, 1989; Newcomb, Maddahian & Bentler, 1986). They are fundamental treatment goals.

In this situation, several things are assumed. First, part of Chris' problem behavior relates to his failed attempts to communicate about various aspects of his life. Second, related to this, Chris needs to articulate his concerns more effectively (Liddle et al., 1992). The therapist works within and between two levels of focus and targets of change. Sometimes, a so-called big picture of relationships is emphasized. These might be broad-level conclusions about one's son or daughter or parent. Particular day-to-day or past relationship events are the components of the big picture central to all therapies. They represent the recollected history and continuing events that have led to the conclusions portrayed in a big picture analysis.

The language in the previous sequence typifies how problems are framed, construed, *and* constructed. Because of our environment and interpersonal relations (Strupp & Binder, 1984), interventions must take into account these complementary processes. Safran and Greenberg's (1991) interpersonal schema (an internal model of relationships derived from experience) is also a clinically practical generic representation of self/other interactions. The interpersonal schemas of Chris and his father are intervention targets. Although the aim is to reduce the problem behaviors of the adolescent, as in all family treatment models, the relationship context (parenting, if we are referring to the father) is related to the adolescent's change.

Although it may appear to be the case, the quest to develop a new Chris gets at something that is not solely intrapersonal. It is important that his father recognize Chris' changes and construe them positively. This begins[5] a cycle that can shape the father's attributions, emotions, and behavior. In family treatment terms, the creation of new relational realities infers that his father's experience of his son changes when Chris' behavior is different, even if only slightly for a brief time or on a less-than-consistent basis. These new or altered perceptions and feelings are ingredients for changing family members' behavior toward each other.[6] Chris' father's emotional reactions to and cognitive appraisal of his son predict future action (e.g., his maintenance of emotional disengagement, his beliefs about Chris' inability to change, and his feeling that he cannot affect any positive change in his son). Hence, they are key intervention targets.

The call for a new Chris relates to how problems are recast in developmental terms. The concept of "possible selves" (Markus & Nurius, 1986) is useful in this regard. The metaphor of multiple aspects of the self and reinvented selves (Cross & Markus, 1991) is common in clinical work (see review in Mahoney, 1984). The metaphor can be an umbrella concept used to orient goals and structure therapy. Therapists talk with teenagers about their possible selves, trying to counter the narrow role in which the teenagers have defined themselves and have been defined by others.

Segment Three: Emotions Inform Theme Development

> T: [to Chris] *Let's try to figure out one aspect of this that I really don't understand. There's something weird that you do with him that is, well, it's like "egging him on" to hit you. How do you understand that?*

The therapist works with Chris to articulate an understanding of his behavior. The therapist realizes that specifying the "facts" of the story is a central therapeutic task.[7] Reestablishing some degree of attachment between father and son takes time and has several dimensions. Clinical families often reside in a chronic emotionally negative environment. MDFT uses multiple channels to change this multivariate network.

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[5] Because this approach is representative of the broader class of systems interventions, it is important to note that the reverse of this conceptualization also is possible (reminiscent of the multidirectional nature of change in intimate relationships). It is equally important for Chris to begin to experience his father in new ways. And altering his father's emotional reactions to and negative predictions about his son's behavior (or even about Chris' lack of trustworthiness or probable unsavory motivations) is key to providing Chris with just such a new experience.

[6] All changes do not lie in the (self-reflexive) network of perceptions one has about oneself and others. Although it is the dimension of the change process that we emphasize here, various other contextual (e.g., extrafamilial, ecological) factors, as well as other intrapersonal factors not emphasized here (such as the role of skill development [communication; problem solving, both cognitive and affective; and general life skills]), affect change. They are omitted because they do not embody the therapy model represented.

[7] This aspect of treatment relies on the interaction between individual sessions with the parent and the adolescent and sessions with both the parent and the adolescent. In individual sessions, the "positions" of each person are discovered or constructed, within the context of a supportive working alliance. These individual sessions serve as a foundation for joint sessions. At the same time, they have value in and of themselves. Change is understood in a multifaceted way, just as problems of adolescence, such as drug abuse, are understood multidimensionally (Newcomb, 1992).

> C: *When I was a little kid, he used to hit me, and now I would hit him, and then I would say, "Yeah, you won't hit me now, you say the only reason you don't hit me is 'cause you love me and you're afraid of child abuse. Why didn't you do that when I was a little kid when I couldn't hit you? Hit me now, go ahead, go ahead."*

Factors such as their temperament, cognitive development, and socialization influence emotional regulation in adolescents (Saarni & Crowley, 1990) and guide the therapist at a time like this. Perceptions of and attributions about one's own or another's temperament may be changeable. Indeed, temperament is now believed to be modifiable as well (Collins & Gunnar, 1990; Goldsmith et al., 1987; Matheny, 1989). Cognitive development may be more difficult to address. Socialization (i.e., parenting) practices are intervention targets, as are an adolescent's perceptions of these practices.

In the previous sequence, one can see movement between descriptions of the past and understandings about someone's motivations in the present. Chris reveals his father's abuse many years ago. Chris' challenge and its insight are profound. What his speech lacks in coherence is redeemed by its intensity.

> T: *So, it's as if you're saying, "I'm paying you back. I remember when you hit me when I was small."*
> C: *And you won't hit me now.*

Gaining retribution for another's past behaviors (Liddle & Diamond, 1991) is a familiar theme in clinical work. Working for forgiveness[8] is the clinical goal with persistent retribution themes. Some clinical researchers have termed materials of this nature core conflictual relational themes (Luborsky & Crits-Cristoph, 1990). The conflict in segment three is an example of how conflict among family members involves multiple layers of content (Vuchinich, 1987).

Conflict resolution has been found to vary as a function of, among other things, the topic of discussion (Smetana, Yau & Hanson, 1991). Clinical experience suggests the content area pertaining to retribution and its antidote, forgiveness, is a complex discussion topic and not amenable to straightforward resolution. However, these areas get a high priority in the clinical model.

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[8] There are degrees, stages, and multidimensional aspects of forgiveness. Forgiveness is less an event and more a process that must be understood in a developmental, temporal context.

Segment Four: Working an Emotion-Related Theme and the Interrelationship of Empathy and Constructivism

T: [to Chris' father] *Ray, I realize that you're goin' through hell right now.*
F: *Not really, I'm coming back.*
T: *Okay. Good. When Chris hits you, according to the best way that he has this stuff put together in his head, with every punch and every kick he is saying, "This is a payback."*

Identifying the retribution theme is only a first step. The following shows how these first-level constructions are transformed and worked in a session.

F: *Yeah, it probably is.*
T: *So, how do you make sense of that?*
F: *I don't make any sense out of it.*
T: *He may never say it, but it's like this kick is for when I was 7, this punch is for when I was 8. He remembers some bad things have happened between you and him. He's saying, "That hurt me when that happened then." And he's saying, "It still hurts me now."* [pause] *I'm not justifying what he's doing, but I am trying to make your son's language clear. Many times, he speaks a different language than we speak. No?*
C: *It's not a good language, that's what I was sayin'.*
T: *Well, no it's not. Do you know what I'm saying, Ray?*
F: *Yes. I know what you're saying.*
T: *When he kicks you, he says, "Screw you," but he also says, "I'm hurt. And you hurt me. And I'm gonna hurt you back. And I'm a big boy now, really big."*
C: *I'm not that big. He's bigger than me.*
T: [again to Chris' father] *So, see what I'm saying here? What I'm trying to get at is, "What is your son's way of talking, what is his language?"*

These passages reveal deeply felt emotions. One clear target of change is the adolescent's behavior itself. However, another target focused on in this sequence, Chris' father, is equally important. It is important to use Ray's role as a parent to reach him. Adolescent participation in decision making (Smetana, 1988), development of the responsiveness (Baumrind, 1991) or empathy (Dix, 1991), dimensions of parenting, and the role of communication of respect to one's teenager (Steinberg, 1990) are other examples research literature identifies as having rich clinical implications. In this vignette, establishing different meanings about Chris' behavior is used to instigate processes that can "unfreeze" his father's perceptions and feelings. This would position Ray to perceive his son's new behavior.

Distinguishing between creating a new understanding of Chris' behavior and appearing to take a position that might be construed as excusing the problem behavior is primary to this process. The seriousness of the problem behavior must not be diminished.

The therapist interprets Chris' remarks to his father: "He says screw you, but he also says I'm hurt. And you hurt me. And I'm gonna hurt you back." Chris was frequently described as a timebomb ready to detonate. Therapy involved debunking these dramatic notions, making Chris' behavior more functional and understandable (but still not an acceptable response to the circumstances).

Both the adolescent and parent are told that their current way of trying to get what they want and expressing complaints is ineffective. Adolescents in particular are then able to sign on to an agenda that avoids "fixing the teenager."

Segment Five: Using an Out-of-Session Crisis To Work a Core Interpersonal Theme

This segment shows how a recent between-session crisis is employed to work key themes. The event is used to reintroduce a primary theme—belief and trust. Inherent in this discussion is the role of the family's past as an influence on emotions and thoughts in the present.

This event is addressed with several goals in mind—the need for (1) reattribution work, (2) a different emotional reaction, and (3) development of behavioral options for the future. The out-of-session event, despite its high emotionality, presents an opportunity to rework the ineffective problem solving. A thorough understanding of the terrain of how negative emotion inhibits problem solving, as Forgatch (1989) and Patterson, Reid, and Dishion (1992) provide, for example, is helpful for a clinician entering into a sequence of this nature.

T: *So, part of what I'm getting at here, Ray, is that I want to clarify Chris' language. Do you think there's anything else that he's saying to you?*

F: [to Chris] *It's just that I don't believe what you were saying to me yesterday.* [sarcastically] *That you owe some drug dealer $135.*

C: *Why do you think my mouth was bleeding for 4 days since I got hit, man? I won't pay him; I already had somebody take care of him, so it's no big deal now.*

F: *Okay, but the thing is, I don't have $135 I can loan you.*

C: *Yeah, it's all right.*

T: [to Chris' father] *Stay with what you were saying. See, you're onto something good.*

F: *The fact is, I did not believe him.*

C: *All right.*

F: *You have conned me in the past. You've even admitted this.*

C: *When?*

T: [to Chris, who is becoming agitated] *Here, sit back. He's not finished.* [The therapist moves closer to Chris and puts his arm around Chris' shoulder.]

C: *He was done talking.*

T: *No, he's not done talking. Wait.* [to Chris' father] *You do not believe him because of…* [The therapist offers an incomplete sentence for the father to complete, as a way of drawing him back into the conversation.]
F: *Past experience.*
T: *Past experience.*
F: *Yeah.*
C: *I…*
T: [to Chris] *Not yet.* [to his father] *Keep going.*
F: *I make my decisions from past experiences.*
T: *Right. Keep going.*
F: *I thought, to tell you the truth, that you were conning me again to buy some drugs, since you* **have** *done it before.*
C: *Can I say something? You want to give me a drug test right now so I can prove to you I didn't do no drugs? And I was scared, man, I didn't wanna come to you, man, because I knew what you were gonna say. You already kicked me out of the house.* [Chris' mood is changing, and he becomes more agitated and angry.] *Only reason I came to you, I was scared. I'm sorry I stooped to your level because I was scared, but I was. I won't come to you anymore.*
T: [trying to slow the pace down and looking for a way to use the new details that have emerged] *Okay, that's interesting.*
C: *I don't like to admit I'm scared, but I was.*
T: [to Chris] *Do you understand what your father's saying, I mean, is that so unreasonable?*

It is important to help Chris understand and gain perspective on his father's point. In a clinical population, perspective taking is a prime goal. Next, with Chris' acknowledgment ("I don't like to admit I'm scared, but I was"), the conversation shifts.

C: *No. He…*
T: *Do you understand that he said, "My first take on this was that this kid is conning me"?*
C: *Yeah, I can understand that.*
T: *Okay, you can understand that, good. The thing that you said that was interesting is that you were afraid because…*
C: *I don't like to admit I was afraid, but I was.*
T: *Okay, why were you afraid? Because there are people who can be pretty weird when it comes to owing other people money, and you could get hurt, and these people would make it clear to you that you are gonna get hurt?*
C: *They already did.*
T: *Ray, I know you didn't hear it this way, but what this kid is saying—now admittedly, let's take this with a grain of salt, but let's say he's telling the truth right now. I want to get back to this thing of "what's Chris' language." Okay? If he is telling the truth right now, his language is telling you, in a not-so-direct way, "I came to you for support." Let's assume, again, that he's telling*

the truth, he was fearful, he was afraid. He came to his father for a form of support and help, and in a sense, protection.

F: *And I let him down again.*
T: *Is it possible that he is telling the truth about this?*
F: *Oh, it's possible.*
T: *Where are you right this instant with this issue?*
F: *I think he probably was telling the truth.*
T: *Really?*
F: *But at the time, I didn't.*
T: *I know. But, I want you to think deeply about this. I want you to really search your soul right now. I don't want you to be afraid to say, "Well, 90 percent* [of me] *says truth, but 10 percent... I'm still unsure." What do you think: 90, 10?*
F: [to Chris] *Let's put it this way, I always want to believe you. I've always tried to believe that what he's saying is the truth. But then I see the facts afterwards, and how things weren't true.*
T: *Right.*
F: *So, I'd say—I'd say 80, 20 that I do believe him.*
T: *Good. See, this is an important lesson for Chris. I think it's very important for him to have an understanding of what your position was. Why shouldn't he understand that you will find it hard to trust, you who have been burned. When he was doing a lot of drugs and was really screwed up, he wasn't the same person; he was lying, he was kidding you, other people, himself most of all. But yesterday, that was an interesting event to try to make sense of. I mean the tragedy of it was that, again, the language was so unclear. I really hear him saying, "I came to you for help. I was afraid."*
F: *Yeah.*
T: *I think it's interesting that he did come to you.*

This segment highlights how to modify extreme stances—all-or-nothing thinking and feelings characteristic of a parent–adolescent impasse (G.S. Diamond & Liddle, 1996).

T: *You flashed back in time; you've heard this before.*
F: *Exactly.*
T: *You thought of half a dozen other incidents where this boy came to you and you reacted. It was like if a person hits his knee like that, see* [therapist hits his knee], *it jumps; it's a reflex. You had no control when he asked you for the money, especially given the way that he asked you—it was absolutely terrible. Again, his language was lousy. See, he was stuck in the past, too. You were stuck in the past with that reaction, but he was stuck in the past, too. Because he couldn't make clear what was going on with him when he asked you that.*

Here, both father and son are portrayed as having had a "relapse" in the way each handled this event. Ray is challenged not to be a prisoner of his past perceptions and feelings about his son. Chris' challenge applies to his timing and methods of accessing his father.

These processes are difficult to change. The therapist is intervening at the intersection of emotion-appraisal, emotion-experiencing, and emotion-expression. Various researchers have described the predictability of these processes. For Shaver and colleagues (1987), "Once one of the basic emotions is elicited, its characteristic action tendencies, cognitive biases, and physiological patterns seem to arise automatically unless they are countered by self-control efforts" (p. 1080). In the clinical situation described here, the self-control and interactional control mechanisms have not functioned for some time. It is this process that the therapist seeks to interrupt and replace.

The following sequence again employs relapse framing as a platform for change.

T: *So, where did the fight end between the two of you?*
F: *You mean today?*
T: *So, yesterday there wasn't any fight?*
F: *No, there wasn't any fight yesterday. Today's when we was comin' on the freeway. He was…*
T: *And that was about the money.*
F: *…goin' off about his hair and stompin' the car. But pullin' somethin' like that when I'm pullin' onto the freeway; I'm lookin' for merging traffic.*
C: *I'm sayin', even if we're stopped I shouldn't of did it. I'm sayin' I'm wrong, but I'm sayin' that's how it happened.*
T: *Okay, that's good.* [pause] *It's too bad things don't happen the way we really think they ought to happen. Things like change.* [To reengage Ray in the dialog, the therapist looks to Ray and again uses an incomplete sentence, cueing Ray to complete it.] *Because we would like a world where when somebody says they're gonna change…*
F: *They change. Right?*
T: [to Chris' father] *They change. So, today, you have to live through something that triggers some terrible things for you, really terrible things. It sends you back. See, he had a relapse today. When he goes off like this, gets angry, stomps in the car.* [to Chris] *Do you know what a relapse is?*
C: *Yeah.*
T: *It's like you got the flu, you're feelin' a little bit better, then all of a sudden, you feel sick again. Okay, you know what it is.* [now to Chris' father] *So, today, he had a relapse. But, you had a relapse, too. Because your relapse is characterized by tremendous doubt about him. Right? What are the elements of the doubt? The most basic of it is, he hasn't really changed. What else? That he can't change?*
F: *No, I think he can change.*
T: *What else? You're in a relapse, you're really feeling bad, and he's just gotten finished giving you a good whack. So what is it characterized by? What else?*
F: *I don't know what you're gettin' at.*
T: *You didn't believe in him in that moment.*

F: *I didn't believe in him when he kicked me in the arm?*
T: *Yeah, you didn't believe that he could be different, that he was gonna be different. Here's the same old Chris, he's just conned me out of money.*
F: *No, what I was gettin' at is, I've seen* [pause], *okay, now I'll tell you what I mean by a relapse.*
T: *Okay.*
F: *I've seen this building up in him. When I picked him and his mother up, and he got in the car, he starts, "I hate this haircut, I hate this car, I don't like this haircut," and he's goin' on like this, and he's goin' on, and I was havin' trouble findin' where you get on the highway. So, I finally figure it out and I go around, and then all of a sudden he starts on the car, and he's really goin', he could put his foot through that thing. I said, okay, here we go again, 'cause I've seen this same…*
T: *Right. Okay, good.*
F: *…the same routine, how it all builds up.*
T: *Okay, good.*
F: *And it builds up, and then here I'm just lookin' to merge and he blindsides me.*
C: *I'm not sayin' I was right, but soon as he said, "Here we go again," I went, oh, okay, he thinks it's gonna go again, might as well.*
T: *Might as well then. Right?*
C: *Right.*

This sequence relates to observations about the role of emotions in interpersonal events. From the perspective of emotions as influencers, "emotions have script-like properties that direct the organization of behavior" (Fischer, Shaver & Carnochan, 1989, p. 123).

Kelley's (1984) concept of intersituational processes is also illustrated in this vignette. For Kelley, "By their very location, the intersituational processes must, like Janus, the god of doors and gates, face simultaneously in two directions, toward the just-ended and the about-to-begin" (p. 92). This sequence shows the retrospective, present, and prospective implications of emotional expression in sessions. Knowledge of this kind helps the therapist broaden the discussion of the negative incident. The relapse notion is given a specific meaning. Both father and son contributed. Chris' part of the relapse was his return to a problematic way of dealing with feelings about his father. His father relapsed, too. His negative beliefs about Chris were automatic, triggered in the heat of an escalating conflict. Ray's belief in his son's ability to change is, theoretically and in practical terms, important to Chris' change.

The therapist interrupts the automatic nature of the processing ("schematic emotional memory mediates emotional responding" [Safran & Greenberg, 1991, p. 8]), as well as its pace, by developing different appraisals and responses.

A specific incident helps the therapist track down, give new meaning to, and rework the emotions around a core relationship theme. In this situation, there are four subtexts to this conversation/intervention.

1. Dealing with emotional events is possible. (This is distinguished from control of one's emotions.)

2. Extreme positions can be avoided.

3. The consequences of negative events of this magnitude hurt everybody.

4. There are advantages for each person in not letting negative interactions escalate.

Segment Six: In-Session Outcome

This segment occurs about half an hour after the baseline segment. The therapist plays a central role in changing the flow of emotional negativity. In these situations, a shift to a cognitive realm is not uncommon.[9] The therapist says that he is "translating" for Chris. This method gives complex emotional themes a reference point in future discussions.

The next segment illustrates something important about the nature of the therapist's subsystem network with the adolescent. The therapist must be careful not to do the adolescent's or the parent's work for him. At the same time, particularly at the beginning of therapy, parents and adolescents cannot be expected to have the ability to bring up sensitive topics with great skill.

> T: *I'm doing something that, ultimately, should not be needed, and I think, will not be needed—and that's translating for Chris.* [to Chris' father] *Do you know what he was telling you with his very immature behavior? One thing that he was telling you was, "Yo, Dad, it really sets me off when I hear your lack of belief in me."*

The word *translating* labels an important stage-specific therapy operation. The therapist first attempts to help Ray shift his view about the event and about his son. Sometimes, processing negative emotions yields more negative emotions. So, when negative emotions run high, it is necessary to begin work on important content of this nature from within the cognitive realm. The therapist ascribes a positive motivation to counter the narrow negative attributions and emotional response of Ray to his son. This treatment establishes complex frameworks about each family member's behavior. From this base, emotions contextualize the past and provide motivation for the present and future.

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[9] This basic intervention strategy, known as a shift intervention (Liddle, 1991), has been identified empirically through a discovery-oriented process research method (G.S. Diamond & Liddle, 1996).

> **T:** *He seems like such a bully sometimes, but there are obviously other sides to him.*
> **F:** *He has a very good side.*
> **T:** [to Chris' father] *It doesn't come out sometimes. He'll get better. But at that moment, what he basically says to you is, "It shattered me that you didn't believe in me, that you thought the bad stuff was coming again." And then, from that point forward, he loses it, and gets very childish: "Oh yeah, so you think it's gonna happen, I'll show you it's gonna happen." Then it's too late. But it's very interesting what he said. That should make you feel that your opinion is important to him. Certainly, your support and your belief in him are important to him.* [to Chris] *Are they not important to you?*

This content elaborates on the "translating" theme. Attachment theory and research inform this intervention. To Chris, the importance of his father's emotional connection to him is stressed. The final statement intensifies and focuses the issue, making sure the father and son understand the new meaning being developed. The therapist's question to Chris, referring to Ray's belief in his son, "Are they not important to you?" creates a personally meaningful and interpersonal in-session experience.

As to whether his father's overt concern is important to him, Chris says:

> **C:** *It is, but a lot of times I act like it's not, and I say, "f___ you, I don't care what you say." I really do care. The only reason I say that is because, you know, I feel like you don't [support or believe in me] so I just—I don't do what you want.*

Chris acknowledges the importance of his father's support and belief. He reveals something critical—sometimes he acts as if this connection is not important. Attributing rejection and disconnection to his father (a common interpretation), Chris protects against future hurt and disappointment.

> **F:** *You know I do care. Right?*
> **C:** *Yeah, most of the time.*
> **F:** *Sure I do.*
> **C:** *I'm not gonna say always, because I don't feel like it's always.*

Although Chris acknowledges some of the father's support, he does not withdraw his complaint. Father and son experience the possibility of negative and positive feelings coexisting. The father reiterates a clear statement of caring for Chris. This is important to note because, although these segments showed cognitive aspects of emotion, MDFT deals with a number of realms of human functioning.

Good moments[10] in therapy (Mahrer, 1988) are way stations, returned to later for elaboration and further work. As is the case with aspects of MDFT,

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[10] The "good moments" method seeks to answer the question: "Given certain in-session patient conditions or states, what therapist operations or methods are useful in helping to bring about what kinds of very good moments of in-session patient change, improvement, movement, progress, or process?"

these achievements are wholes and parts. This segment shows how escalating negative interactions and relationship themes can become more complex and be dealt with directly and positively with a therapist's help.

VI. Procedural Steps: Implementing MDFT—Facilitating Key Therapeutic Processes

Establishing Priorities and Making Decisions

Setting sequences, steps, and content is necessary to help therapy progress. Key guiding questions, such as "Am I focusing on the right content here?" or "Is the affective realm in which I am operating on target?", help the therapist with moment-to-moment decision making in sessions. Therapists enter each session with a specific agenda; throughout the session, the style, content, and focus of the therapist are adapted to accommodate feedback about family members' reactions to the session's events and to the therapist. The ground rules for being attentive to and reading feedback can be made explicit and depend on sound personal judgment under difficult conditions (Liddle, 1985).

Therapeutic Alliance

Attachment, reformulated to fit the developmental period of the second decade of life (i.e., adolescence), has been an important content area in MDFT (Greenberg, Siegel & Leitch, 1983). The clinical corollary of attachment is the therapeutic alliance. MDFT places primary importance on the therapeutic alliances between therapist and parents and between therapist and teenager.

Additionally, alliances must be established with those persons outside the family who are influential in the teen's life, including school and juvenile justice personnel.

These are separate relationships that must be cultivated independently and often differently. (See Adolescent Engagement Interventions on page 62 and Parenting Relationship Interventions on page 107.)

The initial engagement of the therapist and adolescent, therefore, must focus as much on bonding and cohesion as on authority and limit-setting. The therapist accomplishes this, in part, by instituting the developmentally derived expectations of the teenager that may have been abandoned by the parents. The therapist attempts to access areas of the adolescent's competence and interpersonal skill, which serve in small ways to facilitate the teenager's development and also build a foundation for later parent–adolescent communication. The alliance of the teenager and therapist is, at its best, therapeutic in and of itself. Moreover, this relationship also serves transitional functions. It is a bridging context that prepares the teenager for more constructive interchanges with the parents. Thus, the therapeutic relationship is a holon (Minuchin & Fishman, 1981), having both whole and part functions.[1]

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[1] The preparatory aspect of the therapist–adolescent relationship is similar to the therapist–parent relationship. Although different skills and content are involved, the general principles of whole and part functions of the relationship still hold.

Linking as a Mechanism of Change

MDFT conceives of therapeutic change as being multiply determined. Connecting in-session phenomena across sessions reinforces therapeutic continuity. Efforts at generalizing gains made in therapy to the "real" world are enhanced by linking in-session events to tasks for out-of-session change. This is accomplished by linking sessions or parts of sessions across and within sessions to the out-of-session arena. (See Interventions with other family members on page 31.)

Use of Self by the Therapist

Key Concept:

When modeling for parents, a therapist might adopt the role of an extended family member, specifying age-appropriate expectations for teens and providing ways for them to meet these maturity and competence demands.

In part, therapists function as temporary members of a teen's extended family, supplementing the natural functions of the family by providing a rich relational environment with age-appropriate developmental expectations. The therapist must respectfully expect from the teen and the family the developmental or interpersonal skills that they have given up expecting. At times, the therapist may choose to focus on his or her relationships or alliances with the adolescent or the parent. This use of self by the therapist is constituted by a willingness to address the therapeutic alliance. These moments illustrate the sincerity and credibility that have been established between the therapist and the parent or adolescent. The therapist draws on this capital in times of crisis.

Incremental Change

This approach focuses on a successive approximations view of change, despite the fact that change can be defined as having both continuous and discontinuous elements (Liddle, 1982); that is, this approach focuses on working and framing change for family members as a series of small steps.

Therapist Improvisation: Shifting Domains of Operation

In a therapy session, the therapist intentionally shifts the focus from one individual to another, from cognitive to behavioral to affective therapy, or from present to past to allow maximum flexibility for in-session work. When the therapist assesses that a particular approach is not working, he or she shifts the focus to another dimension, such as from the problem solving to the affective realm. For example, a focus on the past is often necessary to help adolescents deal with prior experiences of abuse, neglect, and loss. (See Case Example: Building a Relationship Bridge on page 119.)

Finding the Middle Ground

The high level of emotionality that accompanies parent–adolescent conflict is often associated with extreme opposing stands that pit the parents and adolescent against each other. MDFT seeks to moderate such extreme stands. For example, in a crisis, separate sessions buy time until each party is helped to adopt a less extreme stance and becomes able to constructively address and communicate the strong emotions aroused by the parent or adolescent.

VII. Guidelines for Subsystem Sessions

The conceptual framework of the MDFT approach emphasizes conceptualizing individuals in a systemic manner. However, specifying the guidelines for the practice of a multiple-systems-focused therapy is complex. This section outlines the MDFT guidelines for making decisions about session composition as they pertain to individual sessions and on a week-by-week basis.

Guidelines for Seeing Parents or an Adolescent Alone

1. Build alliances.
    - With parents: "We can, together, come up with some things to do to deal with your son or daughter."
    - With adolescents: "There can be something in this therapy for you."
2. Elicit and hear the story of the past or of the present.
    - Past issues can affect the present.
    - This is what people expect.
    - History is a way to learn about someone.
    - Be careful about orchestrating change too fast.
    - Assess the parents' philosophy, style, and affect or assess the adolescent's perspective on these same dimensions.
    - Assess the parents' hopelessness and despair.
    - Develop the parents' sense of themselves apart from being parents or the adolescent's sense of himself or herself apart from being a son or daughter (Do they take care of themselves? of their relationships? of work?).
3. Assess the functional level of the parents or adolescent.
    - If there are more symptoms—see the parents alone more; lower the level of family goals, craft more "individual" goals with parents. (They are frequently overwhelmed people who have a number of problems themselves—drinking, relationships, money, job stress.)
    - Stabilization is an acceptable goal.
    - Help parents and adolescents deal with each other.

4. Establish a theme.

   - Work hard, show up, prepare for some pain and upset or a relapse; teenagers are different from children; parents can still and need to influence teenagers; assess and influence assumptions about teenagers; don't try to control everything; choose your battles; themes of demandingness and responsiveness; parental and adolescent abdication; hopelessness; and despair.

5. Establish, work, refine, and rework a theme with one person.

   - Should I forgive? Can I forgive? What does forgiveness mean to me? Rekindle parental hopes and dreams, commitment, and love.

   - There are many avenues to change—all change in family therapy is not via enactment or cognition shifts.

   - Work with the self (the parent's or adolescent's).

6. Prevent failure or embarrassment.

   - Parents may not be ready to talk with teenagers and are confused or isolated.

   - The urgency principle says that nothing is more important than keeping the client in treatment; the therapist cannot help if he or she does not have access to the parent and adolescent. Always honor the "urgency principle"—breaks in therapeutic alliances in MDFT are often foreseeable and can be avoided via individual sessions. Sometimes, these are ad hoc minisessions conducted in relation to a whole-family session that occurred on the same day or evening.

7. Prepare parents and adolescents for enactment, negotiation, or sharing.

   - Prepare the parents (keeping marital issues contained, if possible).

   - Soften affect. Establish a cognitive frame around an event.

   - Mobilize hope. The all-important decision to try again must be made overt and be negotiated with great sensitivity and compassion. Hope can be mobilized after a loss of commitment to parenting or to the welfare of one's child. Seeing the parent or adolescent alone facilitates dealing with motivational issues as well as basic issues of empathy and compassion (see Dix, 1991; Dix & Grusec, 1985). A therapist's knowledge of a parent's experiences and conclusions about his or her child is important for working with that teenager. The therapist's work with the adolescent is then done with an appreciation of the context in which the teen must struggle to change the relationship of the adolescent and the parent. Conversely, hearing the teenager's story (and helping to rewrite it) is critical to the therapist's work with the teenager's parents. Just as teenagers are taught how to negotiate and communicate more effectively with their parents, parents are coached on the basis of this inside knowledge of the adolescent.

8. Establish goals.
    - In the early stages, set the foundation; in middle stages, work and rework themes via enactment and tasks that provide continuity across sessions; and in later stages, consolidate (e.g., use cognitive sealing, affective recollections, behavioral troubleshooting, refinement).

Guidelines for Seeing Parents and an Adolescent Together

1. In the early phase, perform intervention and assessment.
2. After at least establishing and accepting a minimal theme:
    - See the parents and adolescent together to establish, work, revise, and rework themes. Therapy is reworking and revising themes.
    - Give examples of themes (e.g., negotiating rights and responsibilities, reestablishing a connection in light of past hurts and disappointments) that have been set with each client alone.
3. See the parents and adolescent together to establish a joint commitment to do something about mutual unhappiness or pain (goals of mutual empathy or perspective-taking).
4. Give family members the opportunity to create new relational realities, to make new agreements, new plans for how they will be together or apart.
    - Small steps and agreements come first (the successive approximations philosophy).
    - Stress the importance of morale.
5. Understand that experiments with change do not necessarily represent change.
    - *Be careful* not to overemphasize in-session events; they are important but not sole determinants of change.
    - Have a multidimensional view of change. Individuals change not only through new experiences of reality but also through understanding and contemplation.

Appendix A. Key Terms and Abbreviations

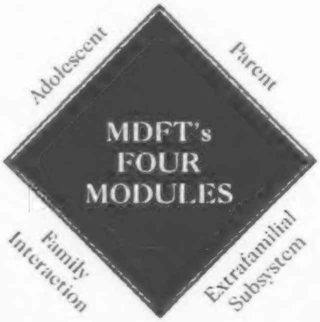
Multidimensional family therapy is a family-focused, developmentally based substance abuse treatment for adolescents (Liddle, in press). As an integrative treatment, MDFT connects to various therapeutic traditions, principally the structural and problem-solving family therapies of Minuchin (1974) and Haley (1976) and various forms of psychotherapy for drug abuse, including behavioral, cognitive, and experiential therapies.

The version of MDFT tested in the CYT study consisted of 12 weekly sessions with the family and individuals in the family, as well as phone and case management contacts. Four areas, each with an empirically established relationship to the development and continuation of adolescent drug and behavior problems, are assessed: (1) the individual adolescent, (2) the parents, (3) the family's interactional patterns and environment, and (4) the teen's and parents' interactions with influential extrafamilial systems, such as schools, the juvenile justice system, and peer and social support networks. Interventions derive from the multisystemic assessment of these four areas and are individualized to each case. Intrapersonal, interpersonal, and ecological aspects of the adolescent's substance abuse and related behaviors are targeted for coordinated and sequential change.

Organizing Terms

Modules (see figure 2) are the (1) areas or realms of therapy, (2) different bodies of knowledge, (3) intervention locales, and (4) pathways to and mechanisms of change.

Figure 2. The Four Modules of Multidimensional Family Therapy



Adolescent module: The realm of therapy related to individual work with the adolescent throughout the three stages of MDFT treatment.

Parent module: The realm of therapy related to individual or joint work with the parents, parental figures, or guardians throughout the three stages of MDFT treatment.

Family interaction module: The realm of therapy related to familial work, such as changing family transactional patterns, throughout the three stages of MDFT treatment. This work focuses on assessing and altering the relationships and interactions among family members.

Extrafamilial subsystem module: The realm of therapy related to work with any system in the adolescent's or parents' social world. Extrafamilial systems may include the school, the juvenile justice system, the adolescent's peer network, vocational or job training programs, medical providers or systems, and social service agencies.

Theory-Related Terms

Developmental orientation: A therapeutic orientation that includes general and specific aspects. At a general level, a developmental orientation is a deep sensibility on the therapist's part that the problems in a youth and his or her family's development thus far are of fundamental interest. Furthermore, because change and adaptation are the overall goals of therapy, developmental orientation reminds the therapist of a fundamental MDFT premise: Every aspect of treatment and of the therapist's behavior aims to redirect the youth and his or her family's development.

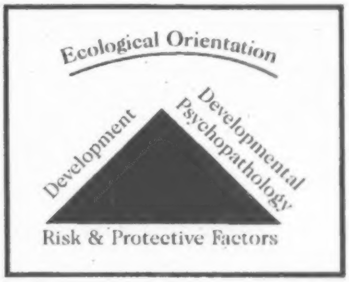
The developmental orientation is actualized through learning about normal adolescent and family development and developmental psychopathology (how problem behaviors form and develop over time). These knowledge bases guide the interventions' design.

Ecological orientation: A therapeutic orientation in which all of an adolescent's and his or her family's psychosocial environments—those contexts that influence the teen's and his or her family's developmental outcomes—are included in the therapist's case conceptualization and (whenever possible) intervention.

Risk and protective factor orientation: A therapeutic framework in which the therapist's detailed knowledge of the ingredients and determinants of good and poor developmental outcomes in families is used to formulate and implement therapeutic action (i.e., promote the kinds of states and interactional processes that enhance development and block those that are related to poor developmental outcomes).

Figure 3 presents the conceptual package of a working relationship of three knowledge bases—normal adolescent and family development, developmental psychopathology (the growth and course of problems over time), and the risk and protective factor framework—and the change strategies and techniques assembled in the MDFT model. The knowledge orientation, change strategies, and most fundamentally a working theory of change are interdependent. Each of these realms is defined in relation to, and interaction with, the other.

Figure 3. Change Strategies and Techniques



Whole and part thinking: Each focal area within MDFT is considered a "holon" (Koestler, 1978)—both a whole and a part. Individuals are "whole" biopsychosocial organisms as well as "parts" of other systems such as families, work or peer systems, communities, and ethnic or racial group systems. Reductionistic clinical thinking and intervention occur when one of these perspectives is overused and others are forgotten or ignored. If a clinician emphasizes changing family processes and does not ask about, take into account, or try to understand how to change adolescent–peer processes, then reductionistic thinking and actions can occur.

Reductionistic thinking is countered by viewing different systems of the teen's world (and this includes intrapersonal and interpersonal systems) as interconnected and mutually influencing. These different aspects of the psychosocial ecology of the adolescent are "nested" structures—they are both wholes and parts, both systems and subsystems. These structures are nested or embedded in increasingly more complex and larger wholes. The multiple ecologies in which teenagers reside are both wholes and parts. A therapist's job is to understand the workings of each system or ecology as both a whole and a part of something and to devise interventions that fit this conceptual framework.

Whole and part thinking is at the core of MDFT. It can refer to how we think about people and also to the conduct of therapy. A session, for instance, has whole functions and is an important aspect of therapeutic work unto itself. It can also be seen as a part—something that is an outgrowth of what has come before, refers to it, and prepares for some new piece of work that is planned or yet to come.

Clinically Related Terms

Family: Parents are central to an adolescent's development. However, other family members, in addition to the parents or primary caretaker, often play key roles in drug taking and maladaptive patterns of teenagers. Siblings, adult friends of parents, and extended family members are taken into account during assessment and interventions. Individuals who play key roles in the life of the adolescent are invited to participate in family sessions, or sessions are held with these individuals alone.

Session: The term session has an expanded meaning in contemporary thinking about treatment programs and comprehensive psychosocial interventions. A therapist's activities can be seen in terms of the therapeutic contact and the variations of therapeutic contact with a case (and the multiple constituents of a case inside and outside the family). Phone contact, for example, is a critical part of the MDFT approach. Also, sessions may take the form of an outing to a movie, a restaurant, or an adolescent-led guided tour of the teenager's neighborhood.

Subsystem work: Subsystem work is done in a meeting in which a therapist convenes the members of different parts or subsystems within or outside a family. The therapist might meet, for example, with only the parents, with the siblings together, or with the mother and son. A program explanation may best be accomplished in a family session, whereas therapeutic engagement is more effectively achieved in individual contacts. Working for a new kind of interaction among family members may require a combination of individual and family sessions that are implemented in a particular sequence.

Break it down: This concept helps the therapist implement a strategy or technique. One reason that interventions fail is that they are not conceptualized in terms of their component parts. Using interventions or other techniques—building relationships with a teen, helping him or her become interested in prosocial pursuits, helping the parent address his or her hopelessness and despair, focusing on and facilitating in-session family interaction—requires the therapist to be able to conceptualize the process or to have a vision of the intended outcome before the event occurs. It is a form of rehearsal and planning in which the component parts and the sequence of a complex action—an intervention—can be mapped out and rehearsed before they are attempted. (See Storyboards later in this section.)

Assessment domains: These are the domains of the adolescent's and family's functioning that MDFT therapists assess. They include family and peer relationships, individual psychosocial competence, communication and social skills, and academic and/or job functioning.

Targets of change: These are important intervention areas of the adolescent or family's functioning that the therapist identifies based on a multidimensional assessment. It is important also to conceptualize the change process, which consists of intrapersonal, interpersonal, and contextual interactions. A sequence of small changes leads to more difficult, larger changes.

Pathways of change: The processes through which change occurs are the pathways of change. MDFT assumes that change in multiple domains of the adolescent's life is both possible and necessary. Furthermore, using multiple pathways may be necessary to change the adolescent's firmly entrenched drug-using lifestyle.

Mechanisms of change: The processes that facilitate change in the adolescent and his or her family are the mechanisms of change. A change mechanism may be both an end in and of itself in one domain (e.g., an intrapersonal or individual realm of functioning) and a mechanism through which change is promoted in another domain (e.g., the interpersonal realm). Changes in parenting practices, an important outcome of treatment in the parenting module, are thought to promote change in the adolescent's functioning.

Themes: The subject of a discourse, discussion, piece of writing, or artistic composition is its theme. A theme can also mean a distinct, recurring, and unifying quality or idea and includes events and circumstances that have significant personal meaning to the client. A theme is representative of core or essential beliefs about oneself, about significant others, or even about how the world works. A theme in a therapeutic context represents a recurring "truth," a consistency in or repetition of events, feelings, or outcomes of relationships. A summary statement or characterization such as I'm "a failure," "a druggie," or "a bad parent" are aspects of and conclusions about oneself that represent thematic definitions.

Therapeutic alliance: The relationship that allows therapeutic work to occur is called the therapeutic alliance. MDFT clinicians must establish and maintain therapeutic alliances with the adolescent, the family, and multiple nonfamilial subsystems. These are separate relationships that must be cultivated independently and in different ways. An important ingredient in successful alliance formation is the discovery and discussion of topics that are meaningful to each party.

Shift strategy: When a therapist needs to change or shift an unproductive (negative, blaming, unfocused) session into a more productive zone—one that is in accord with the session or treatment's goals—shift strategy is used. A shift in the mood, focus, content, and direction of the session is offered when the therapist sees a lack of harmony between what is happening and what needs to happen (to facilitate change).

Storyboards: Session plans that flow from the case conceptualization and are articulated in the mind of the therapist before the session starts are called storyboards. Storyboarding is a planning device: It is a useful way to visualize the steps in facilitating an in-session (short-term) outcome.

A session in the middle phase of treatment often has three steps: one can think of it as a three-act play. The first act sets the stage. Individual sessions with a parent or teen may determine the agenda and develop the details to be worked on in a joint session. The second act may attempt to develop the issues that have been unresolved to date in a face-to-face (parents and teenager) session, to advance the way in which these issues have been addressed, and, if possible, to make concrete progress in resolving these issues in a reasonable, step-by-step manner. The third act may involve closing up the work for that day ("We've made good progress but we've taken this as far as we can today") and setting the stage for the next attempt at moving the issues along, which may occur between sessions or at the next formal meeting of the participants.

MDFT principles: Principles are basic assumptions: important underlying laws required in a system of thought. The principles of MDFT refer to the basic way in which the MDFT approach works. These are predetermined clinical thought and intervention rules that guide the MDFT clinical orientation and behavior. These principles imply what a therapist is to do (i.e., prescribed behaviors) and not to do (i.e., proscribed behaviors) in MDFT.

Case management: This is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the adolescent's and family's needs using communication and available resources to promote quality outcomes. Case management and therapy are integrated in the MDFT treatment program: Case management is therapeutic, and therapy addresses practical everyday concerns and life problems.

Appendix B. Administrative Issues in Implementing MDFT in CYT

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Howard A. Liddle

Treatment

Therapist Training, Supervision, and Protocol Monitoring

Roles of clinical coordinator and supervisor

The clinical coordinator (CC) monitors the implementation procedures and quality assurance measures for the MDFT intervention. A senior therapist with training and skill in the MDFT approach provides clinical supervision of MDFT therapists on a weekly basis. The CC fulfills all other responsibilities related to this position other than routine weekly supervision. These responsibilities include, but are not limited to, monitoring quality assurance, monitoring the intervention protocol, reviewing and rating MDFT tapes on a therapist's adherence to the protocol, training in and supervision of all process measures, daily crisis-oriented supervision as needed, case management, and administration and oversight of all clinically related issues.

Supervision goals

The goals of supervision and monitoring of interventions are to ensure a baseline of quality care and minimize cross-site differences in the delivery of the intervention.

Supervision schedule

All MDFT therapists receive 1 hour of individual supervision weekly. Therapists at the main site receive face-to-face supervision, whereas remote-site therapists receive individual supervision via phone calls. In addition, there is group supervision once a week with all main-site MDFT therapists' meeting together with their supervisor and remote-site therapists' phoning in on a speakerphone conference call. Furthermore, therapists are welcome to sit in during their colleagues' individual supervision, should they desire.

All supervisors are available at other times for phone supervision during a crisis or difficult clinical situation. In addition, the CC is available to all therapists for crisis situations.

Cross-site standardization

The MDFT CC visits sister sites to monitor the implementation and fidelity of the model. These site visits involve review of the onsite quality assurance and monitoring procedures, records review, and, where appropriate, direct observation of treatment activities. Additional visits are scheduled if any problems arise related to model fidelity.

Therapist training

Centralized training in MDFT occurs with CCs and therapists involved with the model and uses lead trainers and work group members who are integrally involved in the design of the intervention. It is conducted by an MDFT-trained therapist and the MDFT supervisor. The formal training is videotaped to orient any new therapist or CC who joins the project. The training provides detailed orientation to the clinical protocol that is used in the delivery of the intervention. The use of onsite principal investigators and other senior staff and consultants who are acknowledged experts in their particular intervention helps ensure that a high level of competence and enthusiasm is conveyed to the therapists who are implementing the MDFT interventions.

Quality Assurance of Treatment

Certification

The CC is responsible for monitoring compliance with common standards set by the CC and intervention-specific standards established by the manual work groups. Monitoring involves a 100-percent review of cases until each therapist achieves the desired quality and competence defined for each site. A therapist's certification in MDFT is determined in consultation with an expert in the model, the principal investigator, coprincipal investigator, supervisor, and CC. The MDFT supervisor discusses all sessions and provides feedback in weekly supervision meetings. Once the desired quality standard has been reached, the therapist is certified.

Certification of MDFT therapists requires six steps:

1. Therapists are required to provide written analyses of four videotaped sessions. They are asked to critique the material, judge the incorporation of the ideas and methods outlined in the manual, and integrate the relevant model-specific theory within the analyses. These analyses are reviewed by the principal investigator, the coprincipal investigator and chief developer of MDFT, and the MDFT clinical supervisor. Therapists receive feedback about their analyses during supervision.

2. Therapists are required to study the manual. The comprehension level required is parallel to that necessary for preparation for a licensing examination. Therapists are asked to complete readings in addition to the manual, such as journal articles and book chapters on drug abuse, family therapy, and adolescent and family development. The MDFT supervisor informs the therapists of these readings and works with them to integrate their content into their MDFT clinical expertise.

3. Therapists present cases to their supervisor in a case-formulation format. This process involves the therapists' studying and presenting their own videotapes. The format for this work is presented in appendix C.

4. The principal investigator, MDFT supervisor, and CC, in consultation with the coprincipal investigator and chief developer of MDFT, review 30-minute segments of three different sessions for each therapist. Then they rate the therapist's competency levels using the MDFT competency measure (Hogue et al., 1998), which is similar to the MDFT postsession measure. Therapists receive feedback on these evaluations during supervision.

5. Therapists are rated on a three-point scale (MDFT competency measure) concerning different elements of the MDFT intervention. To be certified proficient in the model, therapists must score at least a two on each intervention.

6. As this feedback, as well as feedback on the therapist's job performance, his or her handling of the three pilot cases, and his or her behavior and performance in supervision, emerges, the supervisor tailors the skill and model acquisition process to the therapist's strengths and areas in which improvement is needed.

Treatment adherence

Therapists implementing MDFT audiotape and videotape all sessions. After the therapists are certified proficient in their specific model, the CC continues to review and rate a sample of tapes (two sessions per month for each therapist) to ensure continued fidelity of the local intervention. The CC reviews the tapes of all MDFT therapists and completes the quality assurance measure to ensure that the intervention is being applied uniformly as intended. Therapists must be rated at a level of two or above on a three-point scale for various components of the intervention to be considered compliant with the MDFT protocol.

Written documentation

Therapists complete service logs to document all patient contacts and services provided. The logs are revised weekly to check for staff differences in treatment delivery. Therapists also complete a postsession measure after each session. The CC reviews the therapists' ratings on postsession measures weekly. A selected sample (two per month per therapist) is reviewed for quality assurance. That is, the CC completes the postsession measure while reviewing a previously taped session. The two ratings (of the CC and therapist) are then compared for agreement on implementation of treatment-specific interventions during the session.

Chart review

Clinical charts are reviewed by the CC and project coordinator in a weekly individual meeting with each therapist. This weekly review allows senior staff to closely monitor treatment documentation and case flow, maximize standardization, and ensure the completion of charts.

Project Clinical Meetings

Weekly administrative meetings in which the CC, project coordinator, and individual therapists monitor protocol implementation occur each Monday. Charts are reviewed to (1) ensure proper documentation, (2) ensure that measures are completed at the appropriate times, (3) monitor the number of sessions completed, (4) monitor the retention of patients in treatment, and (5) discuss various daily maintenance issues related to the treatments. Case management issues and crisis management are also discussed at this time as necessary. This meeting is not for clinical supervision; that occurs in separate weekly supervision meetings with another supervisor.

Weekly meetings for all clinical staff to address issues relevant to all clinical staff occur on Mondays.

Common Treatment Issues

The following are common situations or problems that arise in treatment. Most can best be managed by skillful screening and assessment and the clear communication of expectations and rules for participation.

Missed sessions

The number of sessions attended by each participant will be recorded to measure the effect of treatment dosage. No formal makeup procedures are used when participants miss sessions. Sessions may simply be rescheduled. It should be noted, however, that treatment is time limited rather than session limited. Therefore, if a patient misses sessions for a few weeks, the period allotted (12 weeks) cannot be extended. Only in extreme circumstances will treatment be extended for a maximum of 2 weeks with permission from the CC.

Lateness

Therapists may still meet with the patient if he or she arrives late. If the therapist has time to see the patient for a full session, the therapist should do so. If the therapist has time to see the patient only for the remaining time of the scheduled session, the therapist should see the patient for that amount of time.

Participants showing up high

Participants who are under the influence of alcohol, cannabis, or nonprescribed drugs are not allowed to participate in treatment that day. This situation calls for further assessment of the need for detoxification, notification of a parent or guardian, and evaluation of potential threats to public safety.

Threat of harm to oneself or others

Participants' threats to harm themselves or others are evaluated and brought into clinical supervision by the therapist. Supervisory review helps determine the best clinical response and the ethical or legal duty to warn someone or intervene. Threats to harm oneself or others should trigger an immediate reevaluation of a problem's severity and modality placement.

Participants receiving collateral services

Participants receiving concurrent services from other agencies are able to participate in CYT. These additional services should, however, be documented so that they can be evaluated as a potential confounding factor related to treatment outcomes.

Abstinence

Abstinence is the desired treatment outcome; however, the requirement for participation includes either a commitment to the goal of abstinence or a willingness to reevaluate the relationship with cannabis and its consequences.

Dropped cases

A patient is dropped from the treatment program after three consecutive no-shows and no substantial contact with him or her. In addition, if a patient or family member does not attend a session in 4 weeks, the case is dropped.

Confidentiality

Data Storage and Staff Access

Each case has two charts. One contains all the research data, and the other contains clinical information relevant to the ongoing treatment (i.e., progress notes). All data related to research questions are kept in the case research file that remains in the research office. This file contains the measures completed during the assessments as well as the measures completed during treatment (e.g., working alliance inventory). Clinical charts are kept in a locked file cabinet in the research office. Therapists may sign out charts and bring them to their respective offices as long as the files are kept in a locked file drawer when not in use. Therapists may hold onto the charts for the entire day but must return all charts at the end of the workday.

Access is monitored through the use of signout sheets. Whenever someone pulls a chart, he or she must sign for it. The signout sheets include the case number, name of person signing out the chart, date of sign out, and date of return. There are two signout sheets, one for clinical files and one for research files. The signout sheets are located in the research office in the file cabinets holding the charts.

When a case is closed, the research and clinical charts are moved to another locked drawer designated specifically for closed cases.

Audiotape and Videotape Storage and Access

All sessions are audiotaped, and some are videotaped. Tapes are stored in a locked storage closet. Access is monitored through the use of signout sheets. Whenever someone pulls a tape, he or she must sign for it. The signout sheet includes the case number, tape being pulled (e.g., session number), name of the person signing out the tape, date of signout, and date of return. The signout sheet is located on the inside of the door of the cabinet in which the tapes are stored. No tapes are allowed to leave the premises other than those sent to the supervising sites.

When tapes are sent to other sites, they are addressed to the CC at the particular site. Tapes do not include identifying information other than participant, site, and therapist identification (ID) numbers; session number; and session date.

Participant ID Numbers

Each file is labeled according to a given case number rather than by the participant's name. Case numbers are preprinted on labels by the coordinating center and are placed on all measures. When cases are discussed, names are not used; rather, participants are referred to by their case numbers only.

Crisis Procedures

All participants are given a 24-hour emergency number at intake. Should a crisis occur during an assessment or therapy session, there are several steps the research assistant or therapist should take, as described below.

Assessing Suicidality and Threat of Harm to Others

The therapist should thoroughly assess the mental status of the individual.

- Is the participant passively thinking about harming himself or herself or someone else, or is there a clear intention?
- Does the participant have a plan?
- Does the participant have the means to carry out this plan?
- Has the participant ever tried to harm himself or herself or someone else?
- Does the participant have outside resources to help him or her through this crisis?

Once this assessment is made, the therapist should help the participant problem solve through the situation, think of alternative solutions, and try to get the participant to make a commitment to safety for a determined amount of time (e.g., can he or she make it through the next 24 hours without doing anything to harm himself or herself or someone else?).

If the participant commits to safety

- Talk to him or her about notifying his or her parents of the discussion. Call the parents to inform them of the participant's vulnerability. Also, talk to the participant about other resources available in a crisis. Make a plan of what the participant will do for the next 24 hours to guarantee safety.
- Notify the crisis hotline of relevant background information or special clinical instructions if there is a reasonable concern that a participant may need to access emergency services after 5 p.m.
- Call the participant at home within 24 hours to ask for an additional commitment to safety. Make a concrete plan of what the participant will do over the next few days to guarantee safety.

If the participant does not commit to safety

If the participant cannot think of alternative solutions and cannot make a commitment to safety, encourage the participant to admit himself or herself voluntarily to an inpatient unit.

If a patient refuses inpatient admission

If the participant does not agree to be admitted and cannot commit to safety, call security to come to the treatment room and notify the parents of the participant's intentions. Try to keep the participant on the premises and notify the on-call psychiatrist of the need for a psychiatric consultation. Together with the crisis clinician, decide whether an emergency psychiatric evaluation is indicated and whether the participant requires an involuntary hospitalization.

If the participant leaves the treatment room without committing to safety, immediately notify security, the police, and the participant's parents. Call the participant's home periodically to stay informed of the situation.

Phone Crisis

If a participant calls with a crisis, first determine his or her location. Then follow the instructions under Assessing Suicidality and Threat of Harm to Others above.

If the participant commits to safety

Follow instructions listed under Assessing Suicidality and Threat of Harm to Others.

If the participant does not commit to safety

Call the police at 911. Explain the urgency of the situation and insist that they go to the participant's location.

If there is a threat of violence

Immediately call security.

If the participant has contraband (e.g., weapons and drugs)

Immediately call security.

Therapists should feel free to call on their supervisor or another member of the clinical staff at any time for supervision, backup, or confirmation of how to handle a situation.

Deciding on a Higher Level of Care

Over the course of treatment, some participants may need a higher level of care. If the therapist suspects a participant needs to be in a higher level of care:

- The question should be discussed with the therapist's supervisor.
- The decision on the most appropriate course of action should be made with the supervisor.
- If the decision is to refer the adolescent to a higher level of care, the therapist should discuss this with the adolescent and his or her parents. An active referral should be made (call the referral source, schedule the first appointment, and perhaps even go with the adolescent to the facility if it seems appropriate).
- If the decision is not to refer someone to a higher level of care, the therapist should continually monitor the adolescent for signs indicating the need to review the decision.

Appendix C. Videotape Analysis Outline/Format

Activity Defined

Therapists complete table 2, below, sketching in the material that fits in each section. They watch a videotape or a large section of videotape and then use the table's format to organize their observations for presentation to supervisors and to one another in a group format.

Goals of the Activity

- Focus on and extend the initial orientation and training content.

- Create an opportunity for an adult learning model to emerge—that is, pull ideas from the therapists regarding their attempts to *apply* the ideas and specifics of the model. Essentially, the table is a perceptual and clinical thinking template that forces the therapist to interpret and discuss a session's events through the MDFT lens. This is a prelude to teaching them case formulation with new or pilot cases. This activity sets the stage for a case formulation activity to happen. In addition, the creation of this template and the therapists' use of it in an automatic way are critical to beginning supervision with all therapists, even those who have done some of this already.

- Create data to understand where to go relative to therapist performance. Additional assessment information is shaped and assessed simultaneously.

Table 2 . Videotape Analysis

	Module (adolescent, parent, interpersonal, extrafamilial)	Stage
1. Thematic focus		
2. Theory connection (theory of dysfunction and theory of function/ normative development/ theory of change)		
3. Intervention intention		
4. Intervention impact		
5. Next steps		

During the analysis, the following questions or issues should be considered:

1. What is the therapist trying to do (e.g., facilitating; blocking; planning; eliciting thoughts, emotions, or statements about behavior)?

2. Why is he or she trying to do this? (By watching the tape, can we read the therapist's mind?)

3. Evaluate key dimensions of the interventions—timing, overall emotional tone, progression of the microsequences in the session, continuity aspects (it follows from what has come before, it platforms some future work very well or not so well, the intervention was fully realized [therapist took the focus and intent far enough]).

4. With an adolescent, be sure to differentiate the area of work—himself or herself or interpersonal aspects (as a family member or as a member of a peer or other system?). Locate the focus in these ways, and insert intention with statement of focus.

5. In the parent module, was the focus with the parent as an adult (e.g., himself or herself or his or her spouse) or was it with regard to the parent in his or her parenting role?

6. In the extrafamilial module, where exactly is the focus—school, community neighborhood, juvenile justice, legal, or medical system?

Appendix D. Summary of the MDFT Research Program

Howard A. Liddle, Cindy Rowe, and Gayle Dakof; the MDFT research program also is summarized in Liddle & Hogue (2001)

Multidimensional family therapy (Liddle, in press; Liddle, Dakof & Diamond, 1991) has received national recognition as an "exemplary" approach for treating adolescent drug abuse. The model was recently highlighted in a major National Institute on Drug Abuse (NIDA) (1999) publication, *Principles of Drug Addiction Treatment: A Research-Based Guide*, which features 12 effective scientifically based approaches for treating drug abuse. The MDFT approach is also highlighted in the 1999 Center for Substance Abuse Treatment (CSAT) publication *Treatment of Adolescents With Substance Abuse Disorders*. It is identified as an exemplary model for drug abuse intervention by the Office of Juvenile Justice and Delinquency Prevention in collaboration with the Center for Substance Abuse Prevention's Strengthening America's Families initiative (www.strengtheningfamilies.org/).

MDFT has been empirically validated in three large-scale, randomized clinical trials in geographically distinct locations: the San Francisco Bay area, central Illinois, and north Philadelphia. It is currently being tested in two more randomized trials in Miami. One of these is evaluating MDFT as a clinically cost-effective alternative to residential treatment for adolescent drug abusers with co-occurring disorders (H. Liddle, *Family-based vs. adolescent residential drug treatment*, NIDA grant no. P50 DA11328). MDFT is also one of 11 treatment models (and the only stand-alone family-based therapy approach) currently being tested in CSAT's Adolescent Treatment Models Initiative (H. Liddle, *Family therapy for early adolescent substance abuse*, CSAT grant no. KD1 TI11871). Finally, as part of NIDA's Bringing Drug Abuse Treatment From Research Into Practice initiative, another new research grant will examine the process and outcome of transporting MDFT into a day treatment program for adolescent drug abusers (H. Liddle, *Transporting family therapy to adolescent day treatment*, NIDA grant no. 1R01 DA13089; Liddle et al., 2002).

The MDFT intervention has evolved over the past 16 years within a research program designed to develop and evaluate family-based drug abuse treatment for adolescents (Liddle & Hogue, 2001). It is an outpatient, family-based drug abuse treatment for adolescent substance abusers (Liddle, Dakof & Diamond, 1991). A distinguishing feature of the approach is its blending of the clinical and theoretical traditions of developmental (Liddle et al., 2000; Liddle et al., 1998) and ecological psychology (Hogue & Liddle, 1999; Liddle & Hogue, 2000) and family therapy (Liddle, 1995, 1999). The approach consists of modules that organize the assessment and intervention into key areas of a teen's current life. Focuses of the approach include the adolescent as an individual and as a member of a family and peer group; the parent as an individual adult and as a mother or father; and the family environment in terms of family interaction, as well as the family members in relation to extrafamilial sources of positive and negative influence.

Close attention has been paid to the development of effective ways to teach MDFT (Liddle & Saba, 1983). The principles of therapy (e.g., focusing on practical, step-by-step outcomes; change through enactment [learning by doing]) are used and reflected in how therapists are trained in the approach (Liddle & Saba, 1985). Therapist training, like the therapy model, takes a multicomponent approach, is sequenced (i.e., phasic), and focuses on competence and skills (Liddle, Becker & Diamond, 1997). Therapists study the manual and related books and articles and learn the key aspects of the approach by watching videotapes of the model in action and videotapes of other therapists being supervised in the approach (Liddle, 1982, 1988). They also learn from videotape and live supervision—a teaching method in which a session is guided by a supervisor while it happens (Avis & Sprenkle, 1990; Liddle, Breunlin & Schwartz, 1988; Liddle & Schwartz, 1983; Schwartz, Liddle & Breunlin, 1988).

In controlled trials, this intervention has demonstrated efficacy with multiproblem, juvenile justice-involved adolescent drug abusers, most of whom were diagnosed with co-occurring disorders (Liddle, Dakof, et al., 2001; Liddle et al., in press a; Liddle & Dakof, 1995). The rigorous nature of this research program and the intervention has been recognized as exemplary (Center for Substance Abuse Prevention/Office of Juvenile Justice and Delinquency Prevention, 2000; Center for Substance Abuse Treatment, 1999; Drug Strategies, 2002; Lebow & Gurman, 1995; Mendel, 2000; National Institute on Drug Abuse, 1999; Nichols & Schwartz, 1998; Waldron, 1997; Winters, Latimer & Stinchfield, 1999). Drug use and delinquency come about over time and as a result of several individual, interpersonal, and contextual processes. Stopping drug use and related difficulties requires a multivariate model. Such an approach takes into account and tries to change the various aspects of the teen's individual functioning and social environment that support the current problem behaviors. The MDFT approach exemplifies this kind of contemporary integrative and complex theorizing and clinical approach. The features and focus of the MDFT approach are consistent with interventions recommended for complex disorders such as substance abuse-intensive, multisystemic, and ecologically sensitive models that target substance abuse and mental health-related dysfunctions (Bukstein, 1995; Kazdin, 1994; Newcomb, 1992).

The model's originator, Howard A. Liddle, has been recognized for his research program on the MDFT model. This includes the 1995 Psychologist of the Year Award from the Division of Family Psychology of the American Psychological Association, the 1996 Outstanding Contribution to Family Therapy Research Award from the American Family Therapy Academy, the 1998 Cumulative Contribution to Family Therapy Research Award from the American Association for Marriage and Family Therapy, and the Excellence in Family Therapy Research Award from the Florida Association for Marriage and Family Therapy (May 2000). In addition, studies on the process of MDFT have been awarded to Guy Diamond (American Association for Marriage and Family Therapy), Susan Schmidt (American Psychological Association and American Association for Marriage and Family Therapy), and Gary Diamond (American Association for Marriage and Family Therapy).

Randomized, Controlled Trials and Studies of MDFT

Four studies have investigated the efficacy of MDFT in significantly reducing drug use and antisocial behavior and in increasing the prosocial, protective factors for adolescent development. These studies are outlined in table 3. They investigated some of the constituent parts or ingredients of MDFT. The samples for all of these studies were substance-abusing, juvenile justice-involved adolescents and their families (Rowe, Liddle & Dakof, in press).

Table 4 provides a summary of different MDFT formats used in controlled trials. In-session parent–adolescent impasses are a major barrier to treatment engagement and outcome. Diamond & Liddle (G.M. Diamond & Liddle, 1996; G.S. Diamond & Liddle, 1999) identified therapist techniques effective in changing dysfunctional in-session family interaction patterns, which are well established as precursors and concomitants to adolescent dysfunction, including adolescent substance abuse. Results indicate that therapists can change the dysfunctional in-session patterns (in-session outcomes) using specific, model-particular techniques (Liddle et al., 2001). This study identified (1) a theory-based way to reliably identify family transactional processes that are known determinants of poor developmental outcomes in children and teenagers; (2) the components of the impasse and the unfolding sequential contributions of both parent and adolescent; and (3) the relation of different therapist actions to the impasse.

Schmidt, Liddle, and Dakof (1996) investigated the nature and extent of change in parenting behaviors, as well as the link between parent change and reduction in adolescent symptomatology. MDFT parents showed significant decreases in negative parenting behaviors (e.g., negative affect, verbal aggression) and increases in positive parenting (e.g., monitoring and limit setting, positive affect and commitment) over the course of therapy. Critically, these changes in parenting behaviors were associated with reductions in adolescent drug use and problem behaviors. Four different patterns of parent–adolescent tandem change were identified: 59 percent of families showed improvement in both parenting practices and adolescent symptomatology, 21 percent evidenced improved parenting but no change in adolescent problems, 10 percent showed improved adolescent symptoms in the absence of improved parenting, and 10 percent showed no improvement in either parenting or adolescent functioning. These results support an elemental tenet of family-based treatments: change in a fundamental aspect of the family system (parenting practices) is related to change at the critical level of interest—reduction of adolescent symptoms, including drug abuse. Furthermore, these data suggest that parenting risk and protective factors for drug use are accessible to intervention within a therapeutic environment.

G.M. Diamond, Liddle, Hogue, and Dakof (1999) investigated the effects of manualized adolescent engagement interventions on improving initially poor therapist–adolescent alliances. Cases with weak therapist–adolescent alliances in the first treatment session were observed over the course of the first three sessions. Significant gains in the working alliance were evident when therapists emphasized alliance-building interventions such as attending to the adolescent's experience, formulating personally meaningful goals, and presenting oneself as the adolescent's ally. Lack of improvement or deterioration in alliance was associated with the therapist continually socializing the adolescent to the nature of therapy. Moreover, in improved alliance cases, therapists increased their use of alliance-building interventions from session two to session three (therapist perseverance), whereas therapists in unimproved cases decreased their use (therapist resignation). Results indicate that, although it is an important early-stage therapist method, when therapists overfocus on and become stuck in orienting adolescents to therapy, and thus wait too long to discuss how the therapy can be personally meaningful for the teenager, a productive working relationship is not formed.

Jackson-Gilfort, Liddle, Tejeda, and Dakof (2001) investigated whether therapeutic discussion of culturally specific themes enhanced treatment engagement of African-American male youth with an inner-city Philadelphia sample of juvenile justice-involved, substance-abusing teenagers. Results indicate that therapist techniques of exploring and addressing particular culturally relevant themes—anger and rage, alienation, and the journey from boyhood to manhood (i.e., what it means to become an African-American man)—were associated with both increased participation by and decreased negativity in adolescents in the very next treatment session. These results suggest that using certain culturally meaningful themes is directly linked to adolescent investment in the treatment process.

Summary

To summarize recent findings on treatment outcomes and processes of MDFT:

- MDFT has been tested in large-scale clinical trials with ethnically diverse, juvenile justice-involved male and female adolescents and has been found to compare favorably with high-quality and commonly used alternative treatments, including adolescent group therapy, multifamily education, and individual cognitive behavioral treatment.

- MDFT reduces drug use and harmful internalizing and externalizing behaviors in adolescents from intake to termination and also maintains treatment gains up to the 12-month followup to a greater extent than alternative treatments.

- Decreases in drug use are accompanied by increases in important prosocial indicators, including school performance (grade improvement) and family functioning. Adolescents in the comparison conditions did not show changes on these important prosocial indicators of developmental success and competence.

Table 3. Summary of MDFT Research

Reference	Treatments Compared	Service Type and Length
Liddle, H.A., Dakof, G.A., Parker, K., Diamond, G.S., Barrett, K., & Tejeda, M. (2001). Multidimensional family therapy for adolescent substance abuse. *American Journal of Drug and Alcohol Abuse.*	MDFT, Peer Group Therapy, and Multifamily Group Therapy	All three treatments were office-based once-per-week treatments delivered in community clinics over a 5–6 month period.
Liddle, H.A., Dakof, G.A., Turner, R.M., & Tejeda, M. (in press b). Treating adolescent substance abuse: A comparison of individual and family therapy interventions. *Addiction.* (Also summarized in Liddle & Hogue, 2001, and Ozechowski & Liddle, 2000.)	MDFT and CBT	Both treatments were delivered in a clinical setting, once per week, over a 5–6-month period.
Dennis, M.L., Titus, J.C., Diamond, G., Babor, T., Donaldson, J., Godley, S.H., Tims, F., Webb, C., Liddle, H.A., & Scott, C. (in press). The Cannabis Youth Treatment (CYT) experiment: A multisite study of five approaches to outpatient treatment for adolescents. *Addiction.*	MDFT, ACRA, and MET/CBT	12–14 weekly treatments were delivered over a 3-month period.
Hogue, A.T., Liddle, H.A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young adolescents: Immediate outcomes. *Journal of Community Psychology.*	Multidimensional Family Prevention (MDFP) intervention treatment condition and a school-based prevention program (randomized design)	Between 15 and 25 sessions were delivered over a 3–4-month period.

Table 3 (continued). Summary of MDFT Research

References	Followup Period	Number and Type of Participants
Liddle, H.A., Dakof, G.A., Parker, K., Diamond, G.S., Barrett, K., & Tejeda, M. (2001). Multidimensional family therapy for adolescent substance abuse. *American Journal of Drug and Alcohol Abuse.*	At discharge, 6 months after discharge, and 12 months after discharge	144 adolescents (mean age = 16) referred for drug abuse treatment. Youth had, on average, a 2.5-year history of drug use and used marijuana 6 or 7 times per week coupled with weekly use of cocaine, hallucinogens, or amphetamines. 50% were minority families, primarily African-American.
Liddle, H.A., Dakof, G.A., Turner, R.M., & Tejeda, M. (in press b). Treating adolescent substance abuse: A comparison of individual and family therapy interventions. *Addiction.* (Also summarized in Liddle & Hogue, 2001, and Ozechowski & Liddle, 2000.)	At discharge, 6 months after discharge, and 12 months after discharge	224 adolescents (mean age = 16) referred for drug abuse treatment. Youth were primarily African-American (72%), male (81%), and from low-income families (70%).
Dennis, M.L., Titus, J.C., Diamond, G., Babor, T., Donaldson, J., Godley, S.H., Tims, F., Webb, C., Liddle, H.A., & Scott, C. (in press). The Cannabis Youth Treatment (CYT) experiment: A multisite study of five approaches to outpatient treatment for adolescents. *Addiction.*	At discharge, 3 months after discharge, and 6 months after discharge	300 substance-abusing adolescents at two sites: Philadelphia, PA, and Bloomington, IL.
Hogue, A.T., Liddle, H.A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young adolescents: Immediate outcomes. *Journal of Community Psychology.*	At discharge	124 adolescents at high risk for drug use and antisocial behavior and their families (97% African-American; mean age = 12.5 years; 44% males). Sample selected over a 2-year period from all youth enrolled in a community-based youth enrichment program in an economically disadvantaged, inner-city neighborhood in a large Northeastern city.

Table 3 (continued). Summary of MDFT Research

References	Outcomes
Liddle, H.A., Dakof, G.A., Parker, K., Diamond, G.S., Barrett, K., & Tejeda, M. (2001). Multidimensional family therapy for adolescent substance abuse. *American Journal of Drug and Alcohol Abuse.*	1. At discharge, 42% of youth who received MDFT, compared with 25% in Peer Group Therapy and 32% in Multifamily Group Therapy, demonstrated clinically significant reductions in substance use: no hard drug use and a reduction in marijuana use from several times per week to 0–2 times per week. 2. At 12 months following discharge, 45% in MDFT, 32% in Peer Group Therapy, and 25% in Multifamily Group Therapy showed clinically significant reductions in substance use. 3. At 12-month followup, 76% of youth receiving MDFT had passing grades (C or better grade point average [GPA])). At intake, only 25% of these youth had a passing GPA. The Peer Group Therapy percentages with passing grades were 43% at intake and 60% at followup; the Multifamily Group Therapy percentages were 35% at intake and 40% at followup. 4. Youth and families receiving MDFT show the most improvement in family functioning as evidenced by self-report and observational ratings (ratings of treatment videotapes).
Liddle, H.A., Dakof, G.A., Turner, R.M., & Tejeda, M. (in press b). Treating adolescent substance abuse: A comparison of individual and family therapy interventions. *Addiction.* (Also summarized in Liddle & Hogue, 2001, and Ozechowski & Liddle, 2000.)	1. At discharge, 44% in both treatments were abstinent. 2. At 12 months following discharge, 70% of youth who received MDFT and 55% of youth who received CBT were abstinent. 3. Analyses employing Hierarchical Linear Models showed a significant rate of change from intake to 12-month followup for youth who received MDFT. Analyses showed significant reductions in marijuana use, externalizing symptoms, and internalizing symptoms.
Dennis, M.L., Titus, J.C., Diamond, G., Babor, T., Donaldson, J., Godley, S.H., Tims, F., Webb, C., Liddle, H.A., & Scott, C. (in press). The Cannabis Youth Treatment (CYT) experiment: A multisite study of five approaches to outpatient treatment for adolescents. *Addiction.*	1. At 3 months following discharge, there was a 27% reduction in marijuana use. 2. At 6 months following discharge, 42% of youth who received MDFT were abstinent. 3. At 6 months following discharge, 65% of youth who received MDFT reported no substance use disorder symptoms in the past month. 4. MDFT was shown to be cost-effective, with its mean and median costs less than costs of standard treatments in the affiliated clinics. The average weekly cost of MDFT was $164 compared with average weekly costs for standard care ranging from $267 to $365.
Hogue, A.T., Liddle, H.A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young adolescents: Immediate outcomes. *Journal of Community Psychology.*	1. All subjects demonstrated significant improvement in three areas: self-concept, substance use attitudes, and school antisocial behavior. 2. Compared with the school-based prevention program, MDFP cases showed greater gains on four outcomes: increased self-concept, a trend toward increased family cohesion, increased bonding to those at school, and decreased antisocial behaviors by peers. 3. Results further suggest that the MDFP cases reversed negative developmental trends: MDFP families reported strengthened family and school bonds and reduced peer delinquency, whereas controls experienced decreases in family cohesion and school bonding and an increase in peer delinquency.

Table 4. Summary of Different MDFT Formats Used in Controlled Trials

Study	MDFT Versions: Therapy Parameters (sessions, dose, intensity)
Liddle, Dakof, et al., 2001	**Completed controlled trial:** Sixteen 90-minute sessions delivered in 16–20 weeks (tested against manual-driven multifamily and adolescent group therapy)
Liddle, Dakof, et al., in press b	**Completed controlled trial:** Sixteen 60–75-minute sessions delivered in 16–24 weeks (tested against manual-driven individual CBT)
Dennis et al., in press	**Completed controlled trial (multisite trial):** 14.2 contact hours delivered in 12 weeks (tested against CRA and MET/CBT5)
Hogue, Liddle, et al., 2002	**Completed controlled prevention trial:** 13.5 sessions over 16.6 weeks (tested against manual-driven school-based intervention)
Rowe et al., in press; Liddle, 1999	**Ongoing controlled trial:** Delivered in 12–16 weeks, moderate intensity intervention, 3 hours per case per week, home-based with some case management services; compared with outpatient group treatment (tested against a manual-driven group therapy)
Liddle & Dakof, 2002; Rowe, Liddle, et al., 2002	**Ongoing controlled trial:** Average 6 months of treatment, intensive services, home-based, several sessions per week, case management; intervention first developed and tested in pilot study in treatment development grant (Liddle, 1994); intensive outpatient compared with residential drug treatment
Liddle, Rowe, et al., 2002	**Ongoing transportation study:** Average 6 months of day treatment in a community setting, MDFT individual and family sessions weekly, MDFT-influenced group therapy and overall behavioral point system, emphasis in later stage of program on transitioning to regular school and aftercare services (single site, technology transfer effects compared with day treatment's baseline, pretechnology transfer intervention)

- MDFT treatment adherence work was successful in developing psychometrically sound treatment fidelity scales. Also, treatment adherence indicated that MDFT can be implemented with a high degree of treatment integrity, lending support to the clarity and usefulness of the treatment manual and the effectiveness of the MDFT training and supervision procedures.

- Several process studies, focusing on the mechanisms of change in MDFT, have linked in-session MDFT interventions with adolescent and parent change on key dimensions during treatment.

Appendix E. Clinical Management of a Multisite Field Trial of Five Outpatient Treatments for Adolescent Substance Abuse

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Abstract

Bridging the gap between clinical research and clinical practice in the treatment of adolescent substance abuse requires empirically validated therapies and technology transfer strategies that reflect an awareness of the realities and resource constraints of local treatment service providers. This article describes the management of cross-site and cross-intervention clinical issues in the Cannabis Youth Treatment (CYT) study, a multisite, randomized, clinical trial of five outpatient therapies. The methods used in the management of such clinical trials could play an important role in elevating the quality of adolescent substance abuse treatment as practiced in the field. This technology involves 1) defining and delineating clinically relevant subpopulations of clients, 2) developing research-supported manuals that define the theory, active ingredients, and procedures of treatment, 3) monitoring therapist adherence to manual-based therapy, 4) monitoring client responses to the procedures as they are implemented, 5) individualizing and refining the delivery of these manual-based therapies within the context of clinical supervision, and 6) conducting rigorous and sustained followup to determine the enduring effects of the interventions.

Carroll and her colleagues (1994) detailed the strategies used to implement and to protect the integrity of three manual-based therapies evaluated within Project MATCH, a multisite study of adult alcoholism treatment (Project MATCH Research Group, 1993). This paper takes a similar approach in describing cross-site clinical coordination procedures within the Cannabis Youth Treatment study, the largest multisite, randomized field experiment ever conducted of adolescent substance abuse treatment. More specifically, the paper details the common clinical infrastructure within which these therapies were implemented across the treatment sites.

It is our collective experience that therapies can fail in the transition from efficacy (outcomes under ideal circumstances) to effectiveness (outcomes in the real world of adolescent treatment), not because of flaws in the interventions themselves, but because of the absence of a sound foundation of clinical management upon which empirically validated interventions are replicated. The construction of stable clinical infrastructures within local treatment programs is as important to the future of adolescent treatment as the availability of research-validated therapies.

The Cannabis Youth Treatment Study

After declining in the 1980s, both licit and illicit drug use among adolescents rose in the 1990s. In 1996, cannabis use by adolescents (8th, 10th, and 12th graders) reached its highest peak in 12 years for reported lifetime use, past year use, and past month use (ISR, 1997). As cannabis abuse/dependence emerged as the leading cause for admission to substance abuse treatment (OAS, 1997), demands increased for research-validated treatments for cannabis-involved adolescents. In response to this need, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) of the U.S. Department of Health and Human Services (DHHS) funded the CYT study.

The CYT study is a multisite, randomized field experiment designed to test the efficacy of five promising outpatient treatment interventions for cannabis-abusing and cannabis-dependent adolescents. Its long-range goal is to provide validated and cost-effective models of intervention that can be widely replicated in local treatment agencies across the country. The study sites include Chestnut Health Systems in Madison County, Illinois (CHS–MC); the University of Connecticut Health Center (UCHC) in Farmington, Connecticut; Operation PAR (PAR) in St. Petersburg, Florida; and the Children's Hospital of Philadelphia (CHOP) in Pennsylvania. The sites represent both academic, research-oriented clinics (UCHC and CHOP) and community-based adolescent treatment programs (CHS–MC and PAR) (Dennis, Babor, Diamond, Donaldson, Goldley, Tims, et al., 1998; Herrell, Babor, Brantley, Dennis, et al., 1999). The CYT study provides a test in geographically diverse environments of treatments that differ in theoretical orientation, delivery format and focus, and dose.

Between June 1998 and February 1999, 600 adolescents (approximately 150 per site) meeting the criteria presented in the *Diagnostic and Statistical Manual of Mental Disorders* 4th Edition-Revised (DSM–IV) (American Psychiatric Association, 1994) for cannabis abuse or cannabis dependence were randomly assigned to one of three conditions, with a total of five conditions used across the four sites. The five conditions include:

- Motivational Enhancement Therapy/Cognitive Behavioral Therapy—5 individual/group sessions (MET/CBT5) (Sampl & Kadden, 2001)

- Motivational Enhancement Therapy/Cognitive Behavioral Therapy—7 individual/group sessions (MET/CBT5 + CBT7) (Webb, Scudder, Kaminer & Kadden, 2002)

- Family Support Network (FSN) (Hamilton, Brantley, Tims, Angelovich & McDougall, 2001) (FSN includes MET/CBT5 + CBT7 plus enhanced family supports: home visits, parent education classes, parent support groups)

- Adolescent Community Reinforcement Approach (ACRA) (Godley, Meyers, Smith, Karvinen, Titus, Godley, Dent, Passetti & Kelberg, 2001)

- Multidimensional Family Therapy (MDFT) (Liddle, 2002).

At UCHC and PAR, adolescents were assigned to a five-session brief intervention (MET/CBT5) or to one of two other interventions that combine more extensive individual and group sessions (MET/CBT5 + CBT7 or FSN). At CHS–MC and CHOP, adolescents were assigned to the five-session brief intervention (MET/CBT5) or to one of two individual/family approaches (ACRA or MDFT). All study participants were assessed at intake and at 3 months, 6 months, 9 months, and 12 months. Treatment completion rates were in the 70-percent range, and followup rates through 9 months after treatment exceeded 95 percent (Titus et al., 1999; Godley, Diamond & Liddle, 1999).

Methodological Challenges

There were three important challenges in conducting this multisite field experiment. The first was to ensure the integrity of each of the interventions being tested (Moncher & Prinz, 1991). Following what has been referred to as the "technology model" (Carroll et al., 1994; Carroll & Nuro, 1996; Carroll, 1997), workgroups led by a technical expert in interventions and a therapist coordinator (TC) responsible for cross-site supervision of that intervention took the following six steps to enhance its integrity:

- Defined and manualized the active ingredients of each therapy, including the frequency, intensity, duration, and sequencing, and indicated responses to the most common problems that occur during delivery of the intervention

- Conducted 15 to 25 hours of centralized, competency-based training for the therapists delivering the interventions and followed this by local certification of staff in each intervention

- Developed a therapist's skillfulness scale to serve as a cross-site measure of general therapeutic competence

- Developed a service contact log to measure therapists' adherence to each of the five interventions and to document the dosage and types of services provided to each client

- Taped and rated sessions for model fidelity (all tapes were rated as part of the cross-site supervision by an expert in the intervention until each therapist was certified, after which two tapes per therapist, per month, were reviewed and rated)

- Conducted weekly (1-hour onsite or telephone) individual supervision and weekly or bimonthly (60 to 90 minute) cross-site group supervision for each intervention.

These procedures helped enhance treatment differentiability (the delineation of the ingredients and procedures that distinguished each treatment from the other treatments) and treatment adherence (the assurance that the interventions [as delivered] maintained fidelity to the original manual-defined procedures) (Hoffart, 1994).

A second challenge involved controlling extraneous factors that could compromise interpretation of the treatment outcomes. To accomplish this, every effort was made to ensure that all general clinical procedures, other than those involved in the specific therapies, would be handled similarly across sites and interventions. This was done to minimize the ability of these contextual issues to unduly influence the evaluation of the experimental interventions and was achieved in two ways. First, staff of the CYT coordinating center conducted two site visits at each of the four service delivery sites to ensure that each site met baseline standards related to arenas such as research protocol compliance, accessibility and appropriateness of clinical space, clinical supervision structure, recruitment strategies, intake and service procedures, confidentiality procedures, crisis and safety net procedures, clinical documentation, data security and storage, and followup procedures. Second, the TCs for each intervention coordinated similar responses to issues that were not part of the specific interventions in monthly conference calls facilitated by the CYT coordinating center. Details of this latter process will be described shortly.

The third challenge was to enhance the external validity of the interventions (the generalizability of study findings) by ensuring that the interventions could be implemented as designed within the resource constraints of settings that currently provide the bulk of services to drug-involved adolescents. It was the goal of the CYT TCs to do everything possible in the CYT study to bridge the traditional gap between efficacy research conducted under experimental (ideal) conditions and effectiveness research conducted in field (real) settings. We wanted to document the kind of clinical infrastructures and the management of day-to-day clinical issues that might need to accompany these unique interventions if they were to achieve comparable results in the field.

The monthly conference calls among the TCs for each of the five interventions and the staff from the CYT coordinating center were particularly helpful in facing the latter two of these challenges. The purpose of these meetings was to define how sites would manage common clinical issues that were not a unique part of the experimental interventions but which, if not identified and controlled, might corrupt the evaluation of these interventions. We were concerned, for example, that if therapists in one intervention expelled adolescents from treatment (and the study) for arriving at a session high, while another site either allowed such adolescents to participate or rescheduled their sessions, differences in completion rates between these sites would reflect not the power or weakness of the interventions but contextual policies unrelated to the active ingredients of each intervention.

What follows is a synopsis of how common clinical issues were managed across the four treatment sites and across the five interventions being tested. It is hoped that this discussion will provide researchers and treatment practitioners alike with insights into the importance of managing such contextual influences. The discussion also represents a snapshot of baseline clinical practices in adolescent substance abuse treatment in 1998 and 1999.

Issues in Clinical Management and Clinical Care

A. Clinical Infrastructure. A rather complex clinical infrastructure was required to effectively manage clinical activities across the four treatment organizations and the five treatments in the CYT study. The care taken in constructing this infrastructure was based on the assumption that there is a close relationship between the quality of clinical supervision and treatment efficacy (Holloway & Neufeldt, 1995).

There were three levels of clinical coordination and supervision in the CYT study. First, local clinical supervisors at each service site coordinated cross-intervention clinical issues and day-to-day clinical problem solving. Second, a therapist coordinator for each of the five interventions used in the CYT study provided onsite and cross-site clinical supervision of staff working in their particular intervention. This supervision occurred weekly during the period in which therapists were being certified and bimonthly following staff certification. Third, a TC at the CYT coordinating center facilitated cross-site and cross-intervention coordination and problem solving. The centerpiece of this cross-site clinical coordination was a monthly meeting at which the respective TCs met with the cross-site TC and research coordinator via a conference call to discuss cross-site clinical and research issues. Particular problems or procedural questions emerging from these discussions were sometimes also referred to the CYT executive committee (all of the principal investigators, the CSAT project officer, and other CSAT staff) for consultation or decision making. The CYT coordinating center validated that the cross-site clinical procedures developed through these processes were in place by conducting two monitoring visits to each of the CYT research sites during the course of the study (*CYT cooperative agreement*, 1999).

Many problems and issues (administrative, fiscal, research, clinical, ethical, legal) were addressed in this multitiered supervisory structure, but the major goals were to meet the methodological challenges noted earlier: ensuring the integrity of the interventions, controlling factors that could confound outcomes, and enhancing the generalizability of findings. Several steps were taken to achieve these goals.

All sites used the same research and service intake and clinical assessment/screening procedures, the same inclusion and exclusion criteria, and the same approach to randomization and waiting list management. To maximize transferability of findings to the field, exclusion criteria were limited to adolescents 1) who needed a higher level of care than outpatient treatment, 2) who presented for treatment with confirmed histories of drug dealing or violence (particularly predatory behavior patterns reflecting a high frequency, high intensity, and long duration), 3) whose psychiatric comorbidity was so severe as to render them inappropriate for the CYT interventions, and

4) whose primary drug of choice was not cannabis. Although the study focused on adolescents with a primary drug choice of cannabis, most adolescents entering the CYT study reported using other drugs in addition to cannabis. Although abstinence from all alcohol and drug use was a goal of the treatments in the CYT study, at admission, adolescents were asked to agree to evaluate their drug use and its effects on themselves and their families. Therapists across sites and interventions agreed that many adolescents' commitment to abstinence was something that should emerge out of the treatment process, not something that should be a precondition for entry into treatment.

Mechanisms to enhance clinical fidelity to the interventions used in the study included centralized training and booster training of clinical staff delivering the interventions, the videotaping or audiotaping of all sessions followed by the use of self- and supervisory-scored adherence measures to monitor skillful execution of the intervention, formal procedures to certify each therapist in the intervention, continued postcertification tape reviews to minimize therapist "drift," and regular cross-site group supervision led by an expert in the intervention.

A considerable portion of the monthly meeting of the CYT TCs was aimed at ensuring baseline clinical processes and data collection procedures were being handled consistently across the four sites. There were discussions of just about everything—from drug testing procedures to appropriate responses to clinical deterioration of a study participant. The monthly agenda included a site-by-site review of particular issues, such as the status of therapists' certifications and the quality of communication between sister sites (those delivering the same interventions), and an opportunity to discuss the general problems and issues encountered. Below are some of the cross-site clinical issues that were of major concern throughout the course of the study.

B. Staff Recruitment, Training, and Retention. Most of the therapists working on the CYT project were trained at the master's degree level or higher, and most had prior training and experience in addiction treatment. The research sites, like the practice field, varied in their use of full-time and part-time staff. Most sites felt there were advantages to having full-time therapists working on the project because that increased their availability to clients, provided greater flexibility in scheduling, and created a greater degree of personal investment in the project. In general, sites looked for individuals with good clinical skills whose overall clinical orientations were congruent with the intervention they were going to deliver. A particular effort was made to find staff who had a good working knowledge of child and adolescent development—a qualification not often found in those working with adolescent substance abusers (Kaminer, 1994). Staff were paid salaries that were at or slightly above the geographical norm for addiction therapists. None of the sites experienced any significant problems recruiting qualified staff.

In the course of the project, there were a total of 26 full-time and part-time clinical positions at the 4 CYT sites. Nine staff left the CYT project during this period—two due to changes in the communities selected as service sites and the majority of the others due to a return to school, family relocation, or promotion. The highest turnover rate was among the case managers. Several things worked to enhance staff morale and retention on the CYT project: a conscious effort to build team cohesion, a knowledge of the potential importance of the research being conducted, the training and supervision opportunities, the opportunity for cross-site contact with peers working on the same intervention, and the flexibility of the individual sites regarding scheduling of part-time employees on the project.

Although considerable effort is made to ensure that conditions in clinical trials are equivalent to natural conditions in the field, there are several characteristics of clinical trials staff that make them somewhat different from those in mainstream practice. Staff who seek clinical positions in clinical trials are not scared away by the limited timeframe of employment on such a project, are often attracted by the intense nature of training and supervision such projects afford, and are not put off by the rigorous record-keeping generally required in such projects.

Strategies used for managing clinical continuity in the face of staff attrition included replicating the training that was provided to all therapists at the beginning of the CYT project, having a built-in transition/training period for entering staff, and using videotaped sessions of the current therapists to train new therapists.

The safety of staff working in the field was enhanced by hiring staff from the local community, providing inservice training on safety management and access to beepers and cellular phones, and the option of working in teams to visit areas that posed higher safety threats. Office-based safety issues were addressed by ensuring that other staff were present while sessions were being conducted and by providing walkie-talkies or silent alarms to signal other staff if assistance was needed. There were no major safety-related incidents experienced by the CYT project.

C. Client/Family Recruitment, Engagement, and Retention. The major barriers in recruiting, engaging, and retaining adolescents and their families were fairly consistent across the CYT project sites:

- Low adolescent/parent motivation for treatment involvement
- The perception that other problems in the family were more important than the drug experimentation of one child
- Parental substance abuse
- The parental view that smoking marijuana is not that big a deal
- Failure to attend due to lack of transportation or child care
- A marital or relationship breakup during the period of treatment involvement

- Inconsistent messages from the parents to the adolescent about the importance of involvement in counseling
- Relocation of the child during the course of treatment
- Parents having given up on efforts to change their child
- A general and pervasive sense of hopelessness about life (felt by both the parents and the adolescent).

Study participants were recruited by direct appeals to youth and parents through newspaper and radio public service announcements and strategically placed bulletin board posters. Staff also oriented local youth service professionals regarding how referrals could be made to the program and the nature of the various treatments that youth would be receiving. These visits and mailings included CYT information packets, business cards, and Rolodex inserts. There was some resistance to referring clients to the project when referral sources discovered that they could not control which intervention their clients would receive. Some were concerned that the five-session intervention would not provide an adequate level of service. After some education about the benefits of brief therapy in general, however, and the need to test such therapies in the substance abuse arena, most were willing to make referrals.

Of 690 adolescents referred to the CYT sites between May 1, 1998, and May 31, 1999, 38.6 percent were referred by criminal justice-affiliated agencies, 24.8 percent by families (7.6 percent of which came from a media promotion of the CYT project), and 15.2 percent by educational community health and human service agencies (Webb & Babor, 1999). An analysis of adolescents admitted to treatment in the CYT study (Tims, Hamilton, Dennis & Brantley, 1999) revealed that 84.7 percent were age 15 or older, 38.1 percent were nonwhite, and 11.9 percent were female. The low rate of female admissions is attributable to at least two factors. The first involves the use of referral sources such as juvenile probation departments that serve predominantly male clients. The second factor is that, of those females referred to the CYT study, more than one-third presented with comorbid psychiatric disorders severe enough to exclude their participation in the study.

Client engagement was enhanced through five broad strategies. The first was to make the transition between the research staff (the equivalent of the intake staff in most agencies) and the clinical staff as personal as possible. When a therapist was not available to be introduced to the client/family by the research staff, the assigned therapist called the parents or the adolescent before the first appointment to introduce himself or herself, begin alliance building, and clarify any questions about treatment participation. All of the CYT interventions begin with an emphasis on empathy and skillful rapport building to build a strong therapeutic alliance and work through resistance related to the coercive influences that may have brought the adolescent to treatment.

The second strategy was for the therapist to speak for 5 to 10 minutes with any adolescent who had to wait more than 2 weeks to begin service (a delay sometimes caused by randomization and the cycles of starting new groups) to sustain his or her motivation for service involvement.

The third strategy was to remove as many environmental obstacles to treatment participation as possible by using geographically accessible service sites, providing assistance with transportation (that is, cab vouchers, bus tokens, picking adolescents up in the agency van), and providing or arranging child care. Case management, whether provided by therapists, case managers (in the FSN intervention), or even during the screening activities of the research staff, was an essential medium of engagement for those families whose lives were most chaotic at the point of initial contact with the CYT project. Every effort was made to link what could be learned in treatment with what could help the immediate crisis presented by the family. The CYT interventions shared the message, "We have something that could help with some of these problems and improve the quality of life for you and your child."

The fourth and most important strategy was to actively engage the adolescents and families by creating strong therapeutic alliances, expressing interest in their participation (e.g., by weekly phone prompts for participation), finding a goal that the adolescent and family were interested in working on, expressing optimism in their capacity to change, and persisting in family contacts during the earliest signs of disengagement. FSN intervention staff felt that home visits were very important in initiating and sustaining the involvement of the most treatment-resistant families.

The fifth strategy was to provide a warm, collaborative, adolescent- and parent-friendly environment (with informal but respectful hosting, providing pizza and sodas as part of the dinner-hour adolescent and parent meetings) and to provide specific incentives for involvement in treatment (help with very specific problems, fully subsidized treatment, and token prizes for homework completion).

D. Safety Net Procedures. Safety net procedures involve strategies for recognizing and responding to adolescents who before or after entering outpatient care were thought to be in need of a higher level of care or allied services. We anticipated and experienced four scenarios that required such safety net procedures. The first involved emergency situations that might arise related to an adolescent's drug use during the course of the study. All parents were provided a laminated card listing signs of acute intoxication and oriented to procedures that could be used to respond to an emergency. The second scenario occurred when adolescents underreported the frequency and intensity of their drug use at intake but disclosed it after they were randomized and admitted to one of the therapies. The third scenario involved the frequency and intensity of use escalating after the adolescent had been admitted to outpatient treatment. The fourth scenario occurred when an adolescent's mental health status deteriorated following admission, particularly where such deterioration posed the threat of harm to himself or herself or others. Safety net procedures were established at all four sites that 1) ensured the periodic reassessment of the status of use and the appropriateness of the level of care to which clients were assigned, 2) ensured the availability and use of supervisory supports to formally reevaluate changes in clients' status and care needs, and 3) facilitated, when needed, moving an adolescent to a more structured and intense level of care or the addition of collateral services. Where alternative or additional services were thought to compromise evaluation of the effect of the CYT intervention, the adolescent and family were provided the additional services but the adolescent was no longer included in the study.

E. Concurrent Services. The exclusion of adolescents with severe psychiatric illness from the CYT study does not mean that all adolescents with psychiatric comorbidity were excluded from the CYT study. The majority of adolescents and families admitted to the CYT study presented with multiple problems, and the rate of psychiatric comorbidity of the adolescents admitted to the study was quite high. Forty-two percent met the criteria for attention deficit/hyperactivity disorder, 55 percent met the criteria for conduct disorder, and 29 percent presented with multiple symptoms of traumatic stress (Tims, Hamilton, Dennis & Brantley, 1999). Those adolescents who were referred for more intense services prior to randomization and who were not included in the CYT study were most likely to be excluded because they presented a high risk of harm to themselves or others. (These risks were identified through the participant screening form completed at intake and through the assessment instrument [GAIN] [Dennis, Webber, White, et al., 1996] and the interviews that were part of the intake process at all of the CYT service sites.)

The multiple problems presented by the CYT adolescents and their families raised an important clinical and research issue: How to respond to the clinical needs they presented without contaminating (through concurrent service involvement) the evaluation of the particular interventions in the CYT study. This problem was complicated further by the referral patterns of the agencies that linked adolescents with the CYT project. Acutely aware of the number and complexity of the problems many of these adolescents presented, many of these referral sources used a shotgun approach—simultaneously referring the adolescent and family to multiple treatments, hoping that the cumulative dose of services would have some positive effect on the child and family. These problems diminished through education of and negotiation with referral sources. It was a policy of the CYT study that adolescents would not be allowed to remain in the study if they were receiving concurrent treatment whose primary focus was the problem of substance abuse or if they were receiving services whose impact was judged by the local staff to inordinately confound the impact of the CYT intervention being provided. However, no adolescent had to be excluded from the study for such concurrent service involvement. Several adolescents who were treated simultaneously for collateral problems (e.g., being medicated for hyperactivity or depression) were allowed to enter and remain in the CYT study because the focus of the concurrent services was not on substance abuse or dependency.

F. Session Management. Efforts were made to ensure that issues related to the management of sessions that were not unique to the particular interventions would be handled in reasonably consistent ways across the sites. Where procedures were not the same, they were reviewed to ensure the differences would not confound outcomes. These discussions included how to respond to lateness, missed sessions, the criteria for dropping cases, intoxication, contraband, disruptive behavior, preexisting relationships between members, and a group session at which only one member is present.

Lateness was handled by degree, by ensuring either that the client got the minimal dose for that session or that the session was rescheduled. Missed sessions were rescheduled or, in the case of group interventions, provided as an abbreviated makeup session prior to the next scheduled session. (All services across the five modalities were expected to be completed within 14 weeks of the time of the first therapy session, with local TCs reviewing and approving any exceptions to this rule.)

All programs made intoxication and possession of contraband grounds for exclusion from that particular session and a flag for reassessment of the appropriateness of the current level of care. (While rare episodes of an intoxicated youth arriving for services did occur, these episodes were clinically managed without excluding the adolescent from continued service.) Only one adolescent per family was included in the CYT study, and preexisting relationships between participants in the group modalities were reviewed to determine whether the prior history would undermine or enhance treatment. A group with only one member present was conducted in a 30- to 45-minute individual format covering the material that was scheduled for presentation. If an adolescent failed to appear for a family session, the session was conducted without the adolescent.

The TCs collectively sought and implemented general strategies that could enhance the effectiveness of sessions for all of the CYT therapies. Strategies that served to minimize problems and enhance session effectiveness included formalizing, posting, and consistently enforcing group/family norms on such issues as dress (banning drug/gang symbols on clothing) and language (profanity, drug argot). In the group interventions, the closed group structure made it particularly important to guard against negative influences within the peer cultures that evolved. A final issue was the appropriate level of contact between therapists and adolescents outside the intervention. The TCs decided that such contact should be minimized so as not to contaminate model fidelity by altering dose. More specifically, it was agreed that all extra-session contact should be responded to within the therapeutic framework of the particular intervention, channeled into upcoming sessions, documented, and brought to supervisors for review.

G. Gender and Cultural Adaptations. While there is significant momentum toward the development of standardized, empirically supported, and manual-based treatments (Wilson, 1998; Carroll, 1997), there is a simultaneous call for the refinement of standardized treatment that includes gender and cultural relevance and effectiveness (Orlandi, 1995). All of the CYT therapists noted making changes in their delivery of the manual-based treatments that were based on gender, cultural, and socioeconomic status (SES) appropriateness. Therapists in group interventions explicitly noted diversity issues in the group and incorporated respect for diversity into the ground rules established at the beginning of each group. The most frequently mentioned adaptations included:

- Changing the language of the session to reflect cultural or geographical norms
- Adding items to some worksheets to make them more applicable to urban youth
- Providing special writing and reading assistance to address illiteracy
- Slowing the pace and adding repetitions of key ideas to accommodate learning impairments
- Developing examples and illustrations of key points that had greater gender, cultural, and SES relevance.

Therapists emphasized it was not the content of interventions that had changed; there were subtle changes in the way that content was framed or delivered.

H. Case Mix Issues. Therapists involved in the group interventions (MET/CBT5, MET/CBT5 + CBT7, FSN) also decided to monitor closely client mix issues according to gender, ethnicity, and other important dimensions. There was an effort to identify any potential iatrogenic effects of randomization (e.g., harassment, scapegoating, or other predatory targeting of a vulnerable group member by other group members) and to actively manage potential negative effects of group support for antisocial behavior (Dision, McCord & Poulin, 1999). This was managed primarily by establishing and enforcing norms for group sessions.

I. Mutual Aid and Peer Support Groups. In contrast to Project MATCH, a 12-step facilitation therapy was not included in the CYT study, and there was some variation in the philosophies of the 5 interventions related to the desirability of mutual aid involvement by cannabis-involved adolescents. The ACRA, MDFT, and MET/CBT interventions do not directly encourage affiliation with addiction recovery support groups, but they do frame such involvement positively if the adolescent is already involved in such a group or self-initiates involvement during the course of treatment. FSN, while strongly encouraging parents to participate in Al-Anon, does not directly encourage adolescent clients to affiliate with Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). Information on local mutual support groups is provided simply as one of many community resources. There was more of an emphasis in all the CYT interventions on involvement in drug-free prosocial activities in general than on addiction recovery support group involvement.

J. Ethical Issues. The TC meetings also provided a venue to discuss and formulate responses to some of the complex ethical and legal issues that can arise in the treatment of adolescent substance abuse (White, 1993). Considerable time was spent discussing questions such as:

- What are the boundaries of confidentiality regarding disclosure of information about an adolescent to his or her parents?
- Do parents have a legal/ethical right to the results of their child's urine tests?
- What circumstances would constitute a duty to report or duty to intervene?
- What obligations, if any, do therapists have in responding to an adolescent's disclosures of past or planned criminal activity?
- How should therapists respond to reports of abuse of adolescents by a parent or to failures by child protection agencies to intervene to ensure the safety of the adolescent?

Discussion

Carroll and colleagues (1994, 1996, 1997) are to be commended for helping transfer the technology model of psychotherapy research to addiction treatment outcome studies. The CYT study greatly benefited from the earlier experience of Project MATCH in the use of this model. This paper has described a structure (the interface between a cross-site and cross-intervention TC group and the CYT executive committee) and a process (monthly meetings of all the TCs and monitoring visits at each CYT study site) that were used to control contextual elements surrounding the experimental interventions. Our goal was to hold these contextual elements constant across the interventions in order to enhance our ability to measure the differences the experimental interventions produced on outcome measures. We wanted differences in outcomes to reflect differences in the interventions themselves and not factors incidental to the interventions.

While there were major research design elements (consistency in clinical data collection instruments and procedures, inclusion and exclusion criteria, and followup procedures) that helped control such variance across sites and interventions, we also sought to identify more subtle areas of potential contamination of the study. By generating consistent cross-intervention procedures to respond to lateness, missed sessions, disruptiveness, intoxication, and concurrent participation in other services, we were able to ensure a consistent and a more precise definition of the dose and type of services provided in, and collateral to, each intervention. By developing and monitoring safety net procedures across the sites and interventions, we were able to ensure timely and appropriate responses to the placement of a client in an inappropriate outpatient modality who needed a higher level of care and to respond to acute episodes of clinical deterioration that warranted a similar change in the level of care. We found that the collaborative work of the TCs helped enhance the methodological rigor of the CYT study and helped establish a sound clinical infrastructure upon which each of the interventions was tested.

There are many aspects of the clinical management of the CYT project other than the efficacy of the particular interventions used that may have wide applicability to the field of adolescent substance abuse treatment. It is our view that many of the procedures to provide overall clinical management of randomized field trials have great clinical utility and are likely to become future baseline clinical practices in the treatment of adult and adolescent substance abuse disorders.

The technology model that, to date, has been used primarily as a means of ensuring methodological rigor in multisite field trials seems to us to have enormous advantages for enhancing the quality of treatment and should be studied for potential adaptation to mainstream clinical practice. Those looking for ways to enhance the quality of adolescent substance abuse treatment would be well served to explore how the elements of this model could become part of the future definition of treatment as usual. Parents seeking help to address the substance abuse-related problems of their son or daughter ought to be able to expect that the theory behind the treatments they are offered can be articulated and that their active ingredients can be defined. They should further be able to expect that these treatments have some degree of scientific support for their effectiveness and that they will be delivered in a manner consistent with procedures whose effectiveness has been validated.

Increased demands for such accountability and fidelity by parents, policy makers, and funding agencies will likely make manual-based therapies the rule in the future, along with the training and adherence measures that accompany them. The technical aspects of cross-site clinical management of the CYT project have much to offer the field as a whole. The use of standardized assessment instruments that are capable of providing comprehensive assessment and treatment planning data should become a requirement of all adolescent treatment programs in the next decade. We further commend the use of central (and booster) training, videotaping and adherence ratings as standard practices in supervision, and cross-site supervision as marvelous tools for training and professional development. Finally, we believe that rigorous followup (monitoring, feedback, and, where indicated, early reintervention) should move from the realm of clinical research to being an expectation, if not a requirement, of mainstream clinical practice. The idea of providing services without measuring outcomes will be incomprehensible in the very near future, and the technology to perform this task is rapidly emerging. Morale among staff working in the CYT project remained high, in part because of the near universal belief in the historical importance of this study and the climate of excitement and discovery that permeated the project. We believe that small field-based experiments to answer critical clinical questions, opportunities for cross-site sharing, and the opportunity to work on papers and presentations can similarly contribute to staff morale within local service organizations. We believe this milieu of curiosity, discovery, and contribution is transferable and sustainable in natural clinical settings. Routine outcome monitoring and field-based experiments, like the other items in this discussion, must simply be moved from the arena of clinical research to the arena of standard clinical practice. This transfer of technology from the research environment to the clinical practice environment, however, will not be simple.

If there is a single weak link in the current practice of addiction treatment that will slow this technology transfer, we believe it is in the arena of clinical supervision. Comprehensive assessments, science-guided treatment planning, empirically validated and manual-based therapies, regular adherence measurement and monitoring, using clients' response-to-treatment data to individualize and refine standard interventions, and rigorous posttreatment followup (and early reintervention, where called for) all flow from the clinical infrastructure at the core of which is a clinical supervisor. If we can elevate the quality of clinical supervision in the field—the selection, training, and support of clinical supervisors to do true clinical supervision—to that of clinical supervision in controlled clinical trials, we will be able to channel knowledge from clinical research to clinical practice.

Conclusions

Clearly defining the demographic and clinical characteristics of client populations, presenting the active ingredients in a manual format and procedures inherent in particular treatments for those populations, monitoring therapists' adherence to such procedures, controlling contextual influences that can influence treatment outcomes, and conducting rigorous and sustained followup to determine clients' responses to particular interventions collectively hold great promise in moving the treatment of adolescent substance abuse from the status of a folk art to that of a clinical science. The technologies used to build this science may themselves offer great potential in enhancing the quality of adolescent substance abuse treatment programs if they can be adapted for routine use in the clinical setting. The CYT study confirms the importance that these new tools can and will have in the future clinical management of adolescent substance abuse treatment.

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